The Society of Surgeons of Trinidad & Tobago

National Grand Rounds 2017

Paper Submission

1. Wunderlich Syndrome: a rare complication of a benign disease

Authors

Bandoo V[1], Goolcharan S[1], Seetahal V[1], Bissoon D[2]

Introduction:

Excluding trauma, there are few genuine urological emergencies and far fewer that are life threatening. While renal angiomyolipomas are uncommon benign tumours, one of its complication is rupture causing significant retroperitoneal hemorrhage, a fatal condition referred to as Wunderlich syndrome.

Case Description:

A 35yr old female presented to the emergency department in class 2 hemorrhagic shock following a 12-hour history of left flank pain followed by a syncopal episode. On examination, she appeared pale with generalised abdominal tenderness and signs of peritonism. After initial resuscitation, her vital signs normalised and subsequently a contrast enhanced CT scan of her abdomen was performed. A large left renal mass was seen with contrast blush, indicating active bleeding. Her initial haemoglobin level was 5.5mg/dL. An emergency left nephrectomy was performed and subsequently her recovery was uneventful. Histology revealed the renal tumour to be an angiomyolipoma.

Discussion:

We discuss the management options of renal angiomyolipomas including surveillance strategies and controversies surrounding the indications for intervention to prevent Wunderlich syndrome

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Paper Submission

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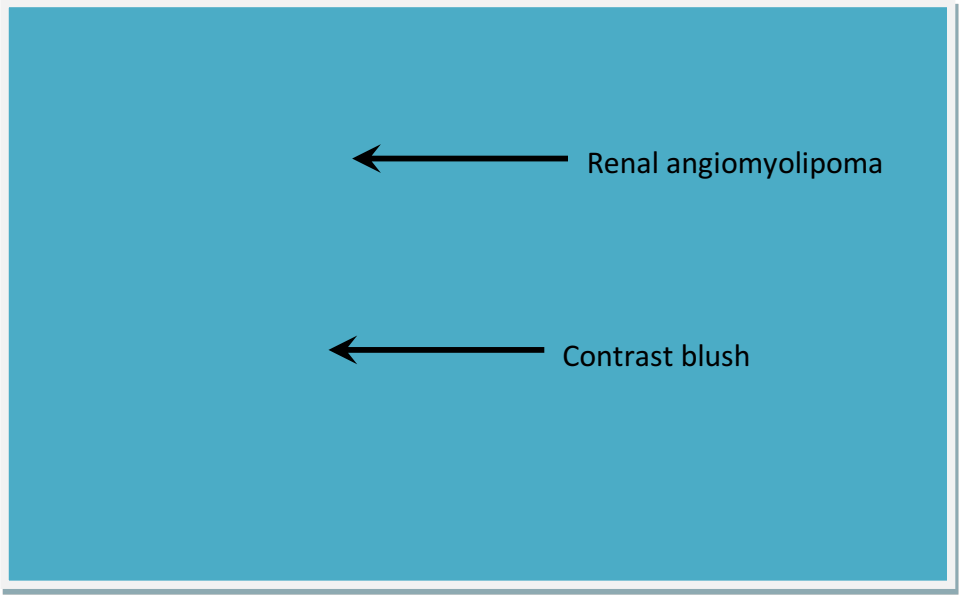

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Paper Submission

2. Modified Puestow Procedure for the management of Chronic Pancreatitis

V Pandohie, N Bobb, Lee-Cazabon H, Maharaj R,

Presenting Author: V Pandohie

Specialty: General Surgery

Word Count : 24

Introduction: Chronic pancreatitis is a progressive inflammatory disease of varied etiology characterized by destruction of pancreatic parenchyma and subsequent fibrosis. Pancreatic duct calculi are a common complication during the natural course of chronic pancreatitis and often contribute to recurrent episodes of abdominal pain. Managementoptions entail endoscopic or surgical procedures, of which the modified Puestow is one of the most commonly used.

Case Description: ST, a 13 year old female initially diagnosed at age 6 with pancreatitis, presented with recurrent bouts of abdominal pain. Blood investigations were within normal limits and Abdominal Ultrasound demonstrated nil abnormalities. CT and MRI abdomen demonstrated obstructing and no obstructing pancreatic duct calculi with pancreatic duct dilatation. A modified Puestow procedure was undertaken initially. However the patient developed an adhesive small bowel obstruction post operatively which resulted in open adhesiolysis and jejunojenal bypass with a feeding jejunostomy insertion following failure of conservative management. Postoperatively, the patient recovered well and was eventually discharged.

Discussion: Surgical intervention is usually required in cases of Chronic Pancreatitis in which abdominal pain is intractable; pancreatic cancer cannot be excluded before surgery; or there are complications involving adjacent organs such as pancreatic pseudocyst. The modified Puestow procedure maximizes the preservation of the pancreatic tissues and minimizes the impact on the endocrine and exocrine functions of pancreas; thus, it is the most extensively applied Chronic Pancreatitis decompression procedure in clinical practice. This was the first case of this nature,in the published literature, done on a patient of this age in Trinidad.

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Paper Submission

3. Red card! A Pancreas Penalty. Is pancreatic resection necessary in the management of grade 3 pancreatic injuries?

Aziz I, Singh Y

Introduction: Severe pancreatic injury that occurs in the setting of sport is often unrecognized due to its rarity and unfamiliarity among healthcare professionals. The current recommendation by EAST suggests that for a grade 3 pancreatic injury a distal pancreatic resection should be performed. Doing so however imparts significant morbidity and mortality with a shortened overall lifespan.

Case Description: A 22-year female footballer sustained abdominal trauma during a match. She presented to the emergency department 48 hours later with signs of peritonitis. A contrast CT with contrast revealed an isolated grade 3 pancreatic injury with complete transection of the pancreas just left of the SMV. After resuscitation, an exploratory laparotomy was performed confirming the CT findings of an isolated pancreatic injury. She was managed without resection of the distal pancreatic segment by performance of a distal pancreaticojejunostomy. Post operatively she continues to show no evidence of pancreatic insufficiency nor did she developed pancreatic fistulas.

Discussion: Is distal pancreatic resection absolutely necessary in the management of Grade 3 pancreatic injuries? The impact of distal resection on morbidity and mortality is significant to warrant at best a case by case assessment for definitive treatment. We demonstrate that as an alternative to the EAST guidelines that pancreatic preservation is a viable option.

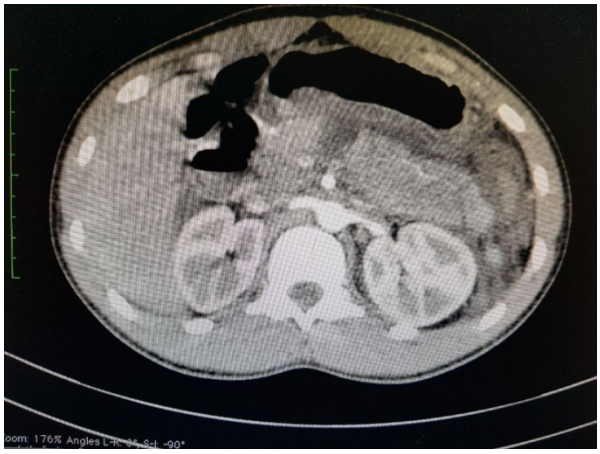

Image 1: Demonstrating a Grade 3 pancreatic injury

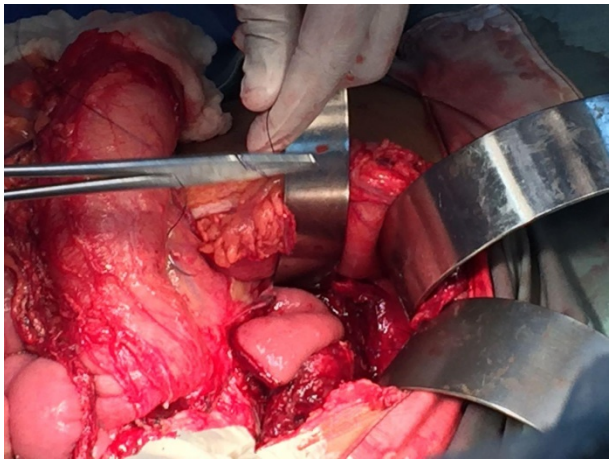

Image 2: Showing the constructed pancreaticojejunostomy

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Paper Submission

4. Pericardiectomy in Constrictive Pericarditis

Mohammed R, Corbin R, Sagubadi S, Ramnarine I

Introduction: Pericardiectomy is the standard of care for Constrictive Pericarditis (CP) with improvement of functional status and low morbidity.

Case Description: 64-year-old male with no known co-morbidities presented with a 6-month history of worsening dyspnea (NYHA class 2), chest pain and dry cough. On clinical examination the only significant finding was non- pitting edema at the ankles. Chest x-ray displayed a boot shaped heart suggestive of right ventricular hypertrophy. Electrocardiogram showed low voltage complexes. Trans-thoracic echocardiogram revealed calcific CP, ejection fraction of 50% and moderate pericardial effusion but no cardiac tamponade. A coronary angiogram showed no significant coronary artery disease. Mantoux and blood investigations were normal.

Near total Pericardiectomy via Anterolateral thoracotomy with on table trans-esophageal echocardiogram was performed. Cardiopulmonary bypass was not used. Intraoperative findings revealed 800mls of bloody pericardial effusion and calcific deposits in the pericardial sac. Central venous pressures improved from 34mmHg intraoperatively to 12mmHg day 4 post-operative. Patient was discharged Day 7 post operatively with no significant morbidity.

Discussion: Why Pericardiectomy & what are the results? Chronic CP can lead to heart failure with slow disease course and nonspecific symptoms. Pericardiectomy aims to improve the cardiac hemodynamics in CP. Results range from improvement of symptoms to no benefit, attributed to timing of operation, surgical approach and extent of decortication.

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Paper Submission

5. THE 'FIBROID' ADRENAL- A RARE PRESENTATION OF A LEIOMYOMA

Griffith L, Samuel C, Alexander R, Raghunanan B

INTRODUCTION

Leiomyomas have traditionally been described arising mainly from the uterus followed by the gastrointestinal tract. They are extremely rare tumours of the adrenal, with only about 20 cases reported in the literature.

CASE

DJ, a 43 year old female with no known comorbidities, was referred for an incidentally discovered right sided abdominal mass, revealed on CT to be 16cm with radiological features of an adrenal malignancy. She was hypertensive at presentation at 158/101. There were no constitutional symptoms and the mass was hormonally inactive.

Following the multidisciplinary team meeting, a biopsy was suggested by the radiologist which was reported as intraabdominal fibromatosis. Patient underwent open right adrenalectomy and partial right nephrectomy. Specimen weight was 2.6kg. Final histology, however, revealed a large leiomyoma. No larger adrenal leiomyoma has been found in the published literature.

DISCUSSION

The approach to an adrenal tumour is governed by its size, functionality, potential for malignancy and whether there exists an indication for biopsy. Tumour size has long been hailed as the strongest predictor of malignancy, with radiological appearances as an important adjunct. The risk of malignancy increases from 38% to 92% for tumours greater than 6cm.

These features all lent to the high expectation of a malignant mass in this case, which highlights the diagnostic conundrum which exists when the radiological appearances do not match the clinical picture.

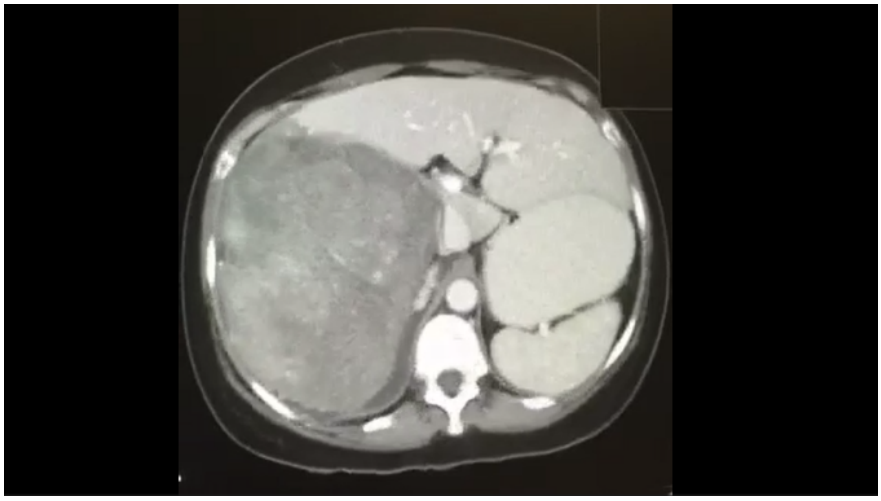

Figure 1. Contrast CT appearance of Adrenal Mass Showing Heterogeneity

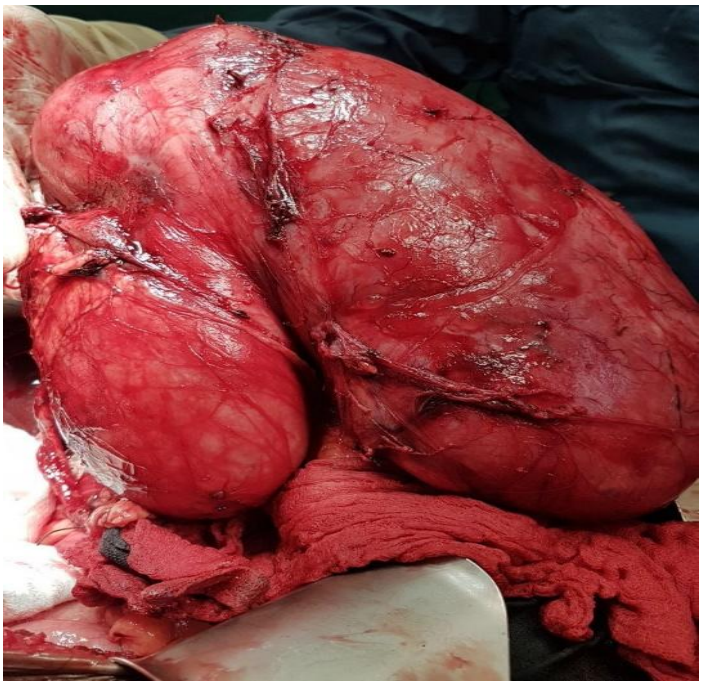

Figure 2. Right Adrenal Mass- Resected Specimen

CONCLUSION

Adrenal leiomyomas can mimic malignancy in their rapid growth and radiological appearances and should be considered as a differential in the diagnosis of a large, unilateral, non-functional adrenal mass.

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Paper Submission

6. A hand in need, indeed!

Pran L, Baijoo S, Baboolal I, Harnanan D

Introduction:

Upper limb amputations are most commonly performed because of trauma (77%). Cardiovascular related disease accounts for a mere 6% of this type of amputations. The level of amputation is primarily defined by the disease process, while keeping in mind the options available for prosthesis and reconstruction.

Case Description:

RB 42-year-old female, with a 20 pack/year smoking history and left hand dominant. Referred to Vascular Team for numbness and paraesthesia of the finger-tips of her left hand. She was previously admitted and managed three-months prior for similar problems. Anticoagulation was commenced and smoking cessation advised, which she was adherent to. Conventional angiography demonstrated occlusion of the second part of the left axillary artery distally. The patient's symptoms progressed to poikilothermia, rest pain and discoloration of her finger tips, indicative of impending gangrene. A series of open vascular therapeutic interventions were performed inclusive of, thrombectomy via brachial artery, re-exploration with segmental interposition vein graft and axillo-brachial bypass using PTFE. Ultimately, a middle forearm amputation was performed six weeks after initial referral.

Discussion: "At which level of amputation offers best functionality?"

Upper extremity amputation is ranked as one of the most debilitating of all amputations. The rehabilitation process of this patient group is a particularly a challenging one. Restoration of functionality is a major concern, inclusive of sensation, gross and fine motor function. As highlighted in the case, these issues are further complicated when the affected upper limb is the dominant one. High rates of prosthetic dissatisfaction and abandonment, fosters the development of mental health issues.

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Paper Submission

7. A rare case of solid pseudopapillary neoplasm of the pancreas in a ten year old child

Bobb N, Maharaj R, Pandouhie V

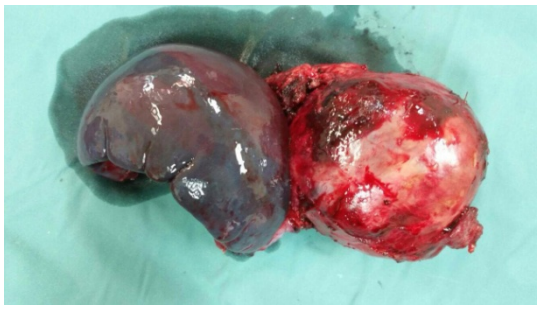
Introduction:

Solid pseudopapillary tumours of the pancreas (SPENs) also known as Franz tumours are the least common of the neuroendocrine pancreatic tumours and have low malignant potential. It typically occurs in young females in the second or third decades of life. It is rare in children with tumours such as neuroblastomas being more common. This uncommon occurrence in children can lead to diagnostic dilemma and unnecessary procedures.

Case description:

The patient began complaining of abdominal pain and her mother noticed progressive abdominal distention. She was subsequently admitted under pediatric surgery at another institution and her initial computed tomography (CT) of the abdomen revealed a cystic tumour involving the tail of the pancreas consistent with a solid pseudopapillary tumour of the pancreas. An open biopsy was performed under general anaesthesia and histology was consistent with a SPEN.

The child was then transferred to Eric Williams Medical Sciences (EWMSC) for joint management under general and pediatric surgery. A repeat CT scan revealed an increase in tumour size with in distinct planes between spleen and posterior stomach. An open distal pancreatectomy and splenectomy was performed and histopathology of the specimen confirmed a SPEN.



Discussion:

Surgical excision has been accepted as the only definitive treatment for SPEN. Recurrences are uncommon and aggressive surgical excision results in cure in the majority of cases. Biopsy however can result in peritoneal dissemination of tumour cells and increase the risk of metastases. Case reports and series in the literature concur good outcomes and minimal morbidity.

The Society of Surgeons of Trinidad & Tobago

National Grand Rounds 2017

Paper Submission

8. And the spleen goes...'POP!' - case of spontaneous splenic rupture

Raghunanan B, Griffith L, Samuel C, Alexander R

INTRODUCTION

Spontaneous, atraumatic rupture of the spleen remains an exquisitely uncommon event, even in today's practice. A likely event following blunt trauma, the association with its occurrence in diseased spleen is less frequent. This life threatening presentation requires an astute, inclined physician to offer timely diagnosis and treatment in order produce the best outcome. Herein, describes an index case of spontaneous splenic rupture secondary to splenic artery thrombosis.

CASE DESCRIPTION

A 64 year old, hypertensive female presented to EWMSC with increasing left upper quadrant abdominal pain. She admitted to a history of splenic infection of unknown aetiology following travels to India one year ago. On admission, the tender left upper quadrant but stable vitals prompted a contrast CT which noted a thrombus in the upper segmental branch of the splenic artery. Subsequently, the patient was anticoagulated. On day three she was found to be in hypovolemic shock and repeat CT showed free intraperitoneal fluid and a massive splenic hematoma. Laparotomy confirmed a ruptured spleen with dissecting subcapsular hematoma. Following splenectomy, her post operative course was uneventful until discharge.

DISCUSSION

Inadvertent, unprovoked splenic rupture may follow chronic pancreatitis or other infective diseases of the spleen as well as after splenic artery embolisation. Its occurrence secondary to spontaneous splenic arterial thrombosis has yet to be described. It remains prudent to link this phenomenon to the covert presentation of splenic rupture, thereby avoiding substantial mortality from delays in diagnosis.

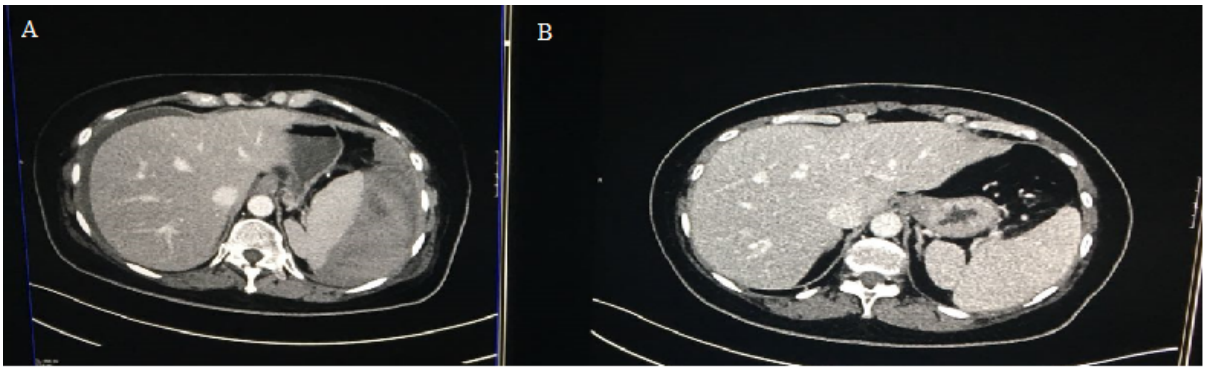


Figure 1 : Showing perisplenic hematoma with free peritoneal fluid (A) compared to an initial normal spleen (B)

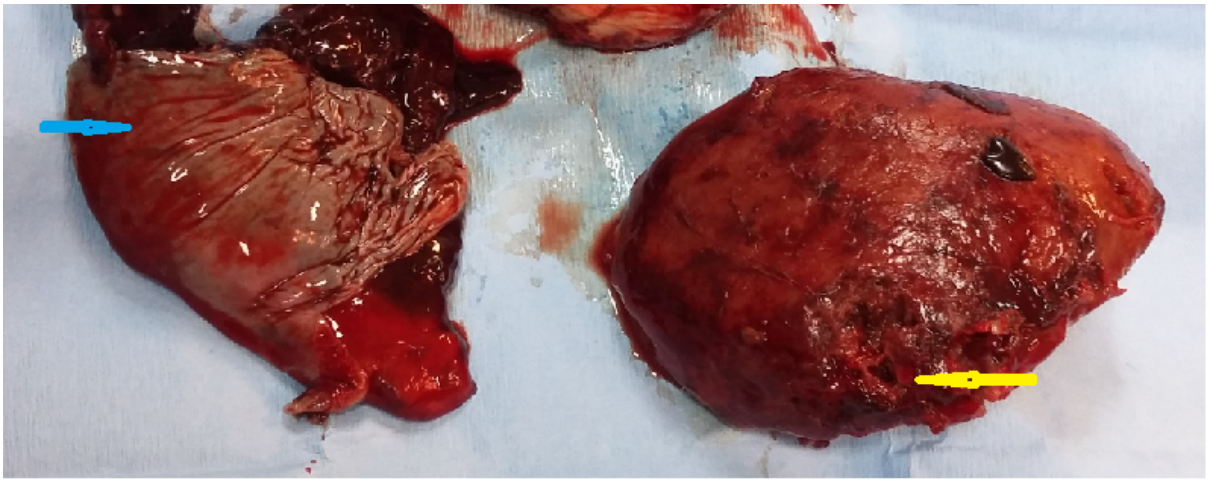


Figure 2: Blue arrow representing splenic capsule with containing hematoma. Yellow arrow displaying isolated defect in spleen (the rupture point)

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Paper Submission

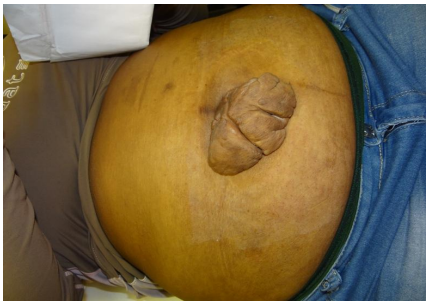
9. That Bloody Keloid -Cutaneous Umbilical Endometriosis: A Case Report

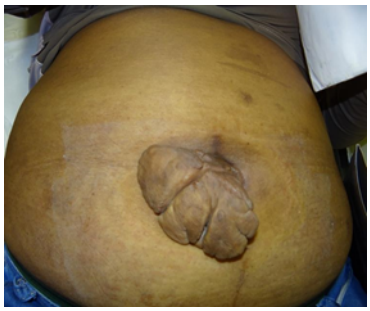
Baron J, Narinesingh S

Introduction: Pelvic Endometriosis is defined as the presence of endometrial tissue outside the uterine cavity . Approximately 1 to 12% of cases found outside the pelvis are typically intra abdominally or within the thorax. Cutaneous Umbilical Endometriosis, where endometrial tissue is found on the umbilicus, is extremely rare and as such is usually misdiagnosed and improperly managed. The case discussed below is that of a 30 year old female with cutaneous umbilical endometriosis who was referred to plastic surgery as a keloid to surgical scar of the umbilicus. Special emphasis is placed on diagnosis and treatment of this phenomenon.

Case Description: A 30year old female, who had a history of myomectomy 7 years ago, was referred to Plastic Surgery Clinic for a keloid to the umbilicus she developed postop. She complained of the keloid bleeding when she menstruated with severe dysmenorrhea . Of significance on examination she was found to have a large pedunclated mass in the umbilical region which was subsequently excised. Histology report showed endometriosis and the patient was placed on gonadotropin releasing hormone agonist

Discussion: Umbilical Endometriosis is rare, and thus, is often misdiagnosed. This patient was seen in several clinics throughout the 7 years post myomectomy for the umbilical mass. Differential diagnoses were made but no definitive management performed. How do we go about managing an umbilical mass in a female with suspicion of endometriosis?





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Paper Submission

Session 2

The Society of Surgeons of Trinidad & Tobago

National Grand Rounds 2017

Paper Submission

A Unique Presentation of Muscle Invasive Bladder Cancer: A Case Report

Leach J, Goetz L, Hosein I, Backredee A

Introduction: Bladder cancer ranks fourth in male cancer incidence and Muscle Invasive Bladder Cancer occurs as a subset in 25% of cases overall internationally but there is a reduced incidence within the Caribbean. This case shows a unique presentation of this disease and its progression with findings of other urologic and gastrointestinal pathology simultaneously.

Case Description:A 67-year old male nonsmoker retired schoolteacher presented with a history of diarrhoea that was not resolving on medical management. Examination revealed an enlarged prostate gland and there were ultrasound findings of a bladder calculus and staghorn calculus of the left kidney with hydroureteronephrosis. Computed Tomography scan of the abdomen showed a trabeculated and thickened urinary bladder with a few locules of air densities associated with perivesical fat stranding. An enterovesical fistula was repaired on exploratory laparotomy and a left nephrostomy tube inserted. Management entailed a combined left nephrectomy, radical cystoprostatectomy with pelvic lymphadenectomy and ileal conduit.

Discussion: This case serves to introduce a peculiar combination of pathology encountered and the multidisciplinary approach to this clinical scenario. The presentation of an enterovesical fistula from a primary bladder cancer with the absence of significant bladder symptomatology only heralded a much more extensive management regime on return of the initial histology report. Further discussion on carefully identifying similar patients and other forms of therapy must be assessed.

Figure 3 Ileal Conduit With Ureteric Stent In situ

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National Grand Rounds 2017

Paper Submission

Multiple Entero-Atmospheric fistulas in a frozen abdomen: a Case report.

N. Cudjoe, S. Sarwan, A. Belle, I. Ojuro

Introduction: Entero-Atmospheric fistulas (EAF) represent the worst possible gradation in the spectrum of two mutually inclusive disease processes: enterocutaneous fistulas and open abdomens. Both disease processes compound each other, producing an extremely fragile physiological patient condition with high morbidity and mortality rates.

Case description: A 67 year old male, with a past surgical history of a laparotomy for small bowel obstruction[SBO], and recurrent SBO secondary to a non-traumatic left diaphragmatic hernia, underwent a scheduled diaphragmatic hernia repair. Initially laparoscopic, the case was converted due to two iatrogenic small bowel injuries. The enterotomies were repaired, and the remainder of the case proceeded well. His recovery was complicated by a high output enterocutaneous [EC] fistula; a life threatening massive upper GI bleed secondary to a posterior penetrating DI ulcer; EC fistula recurrence with concomitant breakdown of an anterior gastro-duodenotomy. After three laparotomies his abdomen was frozen with a fibrotic and retracted abdominal wall. Temporary closure via laparostomy with a Bogota bag was employed. Unfortunately, he leaked again soon after, and many attempts at control of gastric and small bowel leaks utilizing VAC closure, a Silo VAC technique and fistula intubation all failed. After 6 weeks of inpatient care, he succumbed to a hospital acquired infection compounded by a PE.

Discussion: Adult central diaphragmatic hernias are rare, and always warrant repair. There exists a relative paucity of literature on the management of EAF with multiple fistulas, proximal fistulas, and a frozen abdomen all representing the worst case scenario. Of variety of methods used to manage EAF [ranging from simple VAC dressings, Silo and nipple VAC, VAC chimneys, fistula plugs and patches, and re-conversion into an ECF via a stoma], which technique is best?

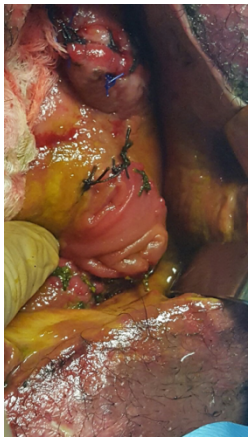

Figure 1: Multiple EAF with breakdown of previous repairs

Figure 2: Modified Silo VAC technique with syringes over the enterotomies

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Paper Submission

Management of Solitary Radioiodine Resistant Metastatic Thyroid Cancer

Richardson R, Hassranah D, Olivier L

Abstract

In thyroid cancer 5% of patients will develop metastatic disease which fails to respond radioactive iodine. Their disease is more aggressive and carries a high mortality. Recurrences in the neck usually occur in the thyroid bed or in regional lymph nodes.

A 51 year old female with known papillary thyroid carcinoma with previous total thyroidectomy and metastasectomy of the thymus presented with a 1.2cm Level III lymph node in close proximity to the left internal jugular vein. This was negative on her previous radioiodine scan and had not responded to radioiodine ablation therapy since her initial therapy. A modified radical neck dissection was performed with removal of Level III, IV and V lymph nodes and resection of the clavicular head of sternocleidomastoid. A minor complication of thoracic duct leakage occurred which was managed conservatively with compression dressings, aspirations and low fat diet. Histology confirmed 1 of 24 lymph nodes positive for papillary carcinoma.

Surgery is the mainstay in the management of recurrent neck metastases and gross nodal disease in thyroid cancer with up to 50% of patients being disease free in short term follow up. Complete ipsilateral compartmental dissection and modified neck dissection should be performed as opposed to “berry picking” and selective lymph node resection.

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Paper Submission

Miles of Ernest

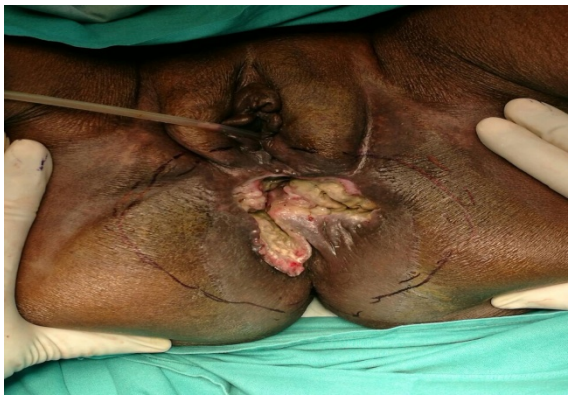
A. Arra, S. Jugool, Lalla R, Dan D

Introduction: The latter half of the last century has seen the maturation and recognition of the multitude of specialities that comprise the field of surgery. The modern surgeon must recognise the expertise of his/her specialist colleagues and actively seek their advice and assistance when necessary.

Case Description: A 63 year old woman presented to us with a history of per rectal bleeding and anal discomfort. Clinical examination revealed an obvious anal carcinoma, confirmed on histology. CT staging revealed no evidence of metastatic disease and so after MDT discussion she was referred for therapeutic chemo-radiotherapy. The patient had a moderate response and was offered an APR.

Resentful of a stoma she eventually consented to an APR 4 months later. Although the disease was confined to the anus it was larger and infiltrated the posterior wall of the vagina. This was done with a team comprising a Gynaecologist, General surgeon and Plastic surgeon. The APR and perineal reconstruction with a VRAM flap was completed with an uneventful intra-operative course. A hysterectomy was included as the uterus (16/40) bore multiple fibroids and appeared unhealthy. Unfortunately, she has developed a surgical site infection which may have adversely affected the VRAM flap. This is being managed with drainage, debridement as necessary and VAC therapy.

Discussion: Modern surgical practices require the recognition and respect of the various specialties available to us. It is important to assemble the best advice and skill at all stages in the management of patients with complex diseases. This will reduce the numbers of missed opportunities to achieve the best possible outcomes for the patient and for ourselves.



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Paper Submission

Treating the hole problem

Baijoo S, Manjunath G, Pran L, Mamed D

Introduction: An internal hernia is defined as the protrusion of a viscus through the peritoneum or mesentery into a space within the abdominal cavity. One such example is herniation through the foramen of Winslow which accounts for approximately 8% of all internal hernias. The diagnosis requires a high index of clinical suspicion, since signs and symptoms are usually non-specific.

Case Description: A 45-year-old male presented with a one-day history of peri-umbilical pain, which became generalized and gradual increased intensity. He also complained of progressive abdominal distension. Contrast computer tomography scan of the abdomen demonstrated a paraduodenal herniation with possible strangulated small bowel. The lesser sac was found to contain necrotic small bowel which when reduced was confirmed to be a segment of ileum, approximately 50cm in length at laparotomy. The gangrenous portion was resected and a primary anastomosis was performed. The patient had an uneventful post-operative course with no reported recurrence after 6 months of follow up.

Discussion: The foramen of Winslow is a potential site for internal hernia as it forms a communication between the greater and lesser sac. Although this a normal anatomic structure there are variants which increases the probability of herniation. These include an abnormally enlarged foramen, pendulous small bowel mesentery, elongated right hepatic lobe, lack of caecal and ascending colon zygoses and a defect in the gastro-hepatic ligament. The list above highlights some congenital causes for internal herniation, however consideration should be given to iatrogenic measures which can reduce or promote internal hernia formation.

A Case of Mistaken Identity

Kawal T, Sooknanan K, Ramsoobhag K

Introduction: Patients with incontinence after gynaecological surgery must be thoroughly investigated for genito-urinary injuries, using both imaging and endoscopic techniques. Where conservative and surgical treatment options exist, management should be tailored to the clinical scenario. We report one such case of a ureterovaginal fistula.

Case: A 51 year old female presented 5 weeks following a Total Abdominal Hysterectomy complaining of persistent uncontrolled leakage of clear fluid from the vagina. Cystoscopy and instillation of methylene blue revealed no identifiable vesico-vaginal fistula. Micturating cystourethrogram noted a communication between the bladder and vagina that appeared to be located posteriorly and superiorly. Intraveonus urography was unable to detect the presence of the patient's left kidney(Figure 1). Repeat cystoscopy and retrograde contrast imaging of the ureters was performed. Again, the methylene blue test was negative. However, a retrograde ureterogram study failed to outline the left ureter. The patient underwent a left nephrostomy following which the incontinence resolved. An antegrade ureterogram demonstrated extravastation with vaginal leakage. A diagnosis of left uretero-vaginal fistula was made and a left ureteroneocystostomy and psoas hitch was performed (Figure 2).

Discussion: Although ureteric injury during gynaecological surgery is well documented, the occurrence of a Uretero-vaginal fistula is uncommon. The index of suspicion is high with previous gynaecological surgery and persistent incontinence in the absence of a demonstrable vesico-vaginal fistula. The best approach to investigating and treating this condition remains debatable.

Figure 1: Intravenous Urogram with absence of contrast in the left pelvicalyceal system

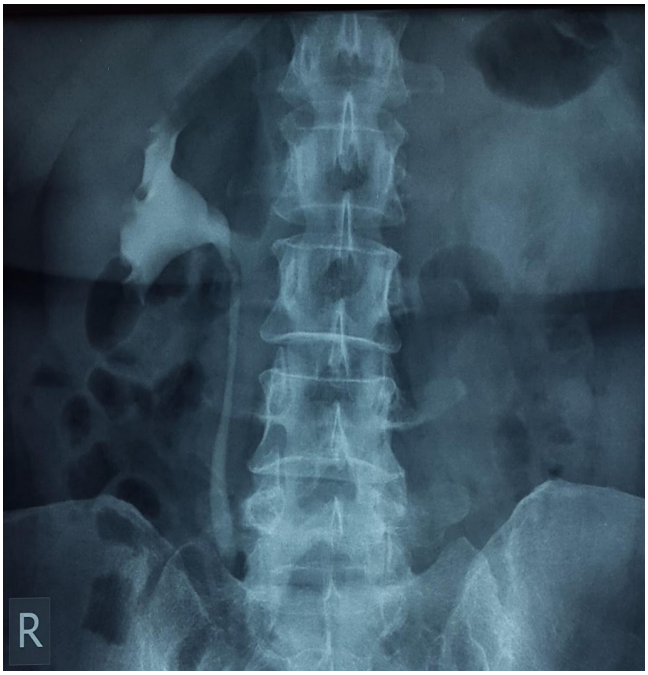
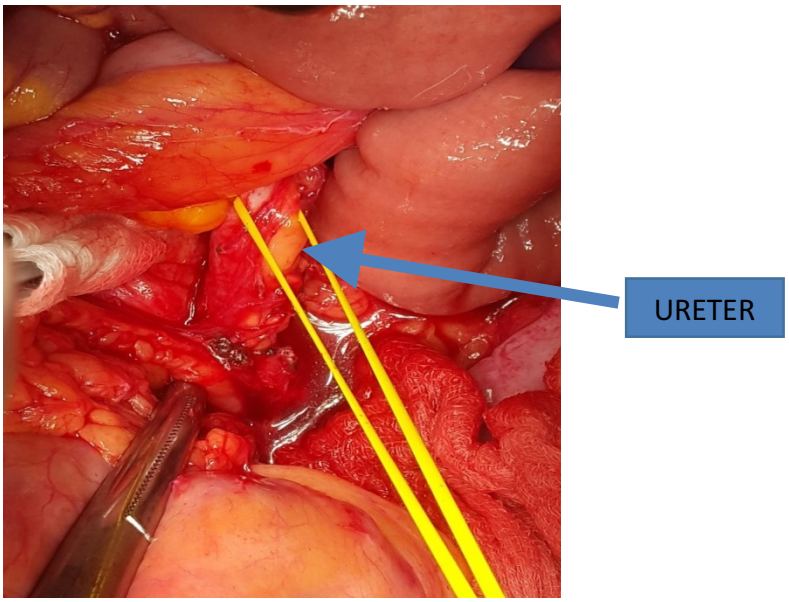


Figure 2: Isolation of left ureter and dissection to fistula site


URETER

The Society of Surgeons of Trinidad & Tobago

National Grand Rounds 2017

Paper Submission

Razor Blade Esophageal Perforation

Sagubadi S, Bobb J, Paladee V, I Ramnarine

Background: Oesophageal perforations often present with diagnostic and therapeutic dilemas. We discuss the options and rationale.

Case Description: A well 45 year-old male presented with a one week history of dysphagia and a bright red upper GI bleed. Oesophagoscopy showed an ulceration of the esophageal mucosa with a razor blade embedded at 25 cm from the incisors. CT neck and chest with oral and IV contrast showed the razor blade in the proximal oesophagus, an associated tear and an air-containing paraesophageal collection. The patient was referred to the Thoracic Surgical Unit.

The patient underwent bronchoscopy (normal) and repeat oesophagoscopy.

A right postero-lateral thoracotomy, toilet, primary closure of perforation and intercostal flap buttress was performed. The foreign body required a distal esophagotomy to remove it. A feeding jejunostomy, nasogastric tube and intercostal drain were placed.

Post-operative recovery has been without complication.

Discussion: This was a young fit man with a delayed, but contained leak. A variety of conservative and non-operative options were considered but would likely to worsen. An operative approach involves several complex decisions: who and where to operate; which incision(s); oesophageal exclusion, stent use; feeding and drains. The right thoracotomy provides access to the entire oesophagus while a left approach is more useful in Boerhaave Syndrome. A feeding jejunostomy or naso-jejunal feeding tube is essential during recovery.

These options are presented for further discussion.

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Paper Submission

A Giant Retroperitoneal Liposarcoma in a Jehovah's Witness: a case report and review of current treatment

Muddeen A, Ramdass , M.J. Oladiran A, Fraser O

INTRODUCTION: Retroperitoneal Liposarcomas (RLS) is a relatively uncommon and heterogenous tumor. They are often difficult to manage due to its size and deep location and consequently the majority will recur. The gold standard of care remains attempt at complete surgical resection.

CASE: We report a case of a 53 year old male who presented with a five month history of progressive increase in abdominal girth. Of note, the patient was anemic but a Jehovah's witness and refused any blood products. He subsequently underwent surgical resection for a giant retroperitoneal liposarcoma weighing 18kg.

DISCUSSION: Retroperitoneal liposarcomas (RLS) are uncommon tumors accounting for 0.02-0.2% of all neoplasms. Patients are often asymptomatic until the tumor is very large and therefore present a challenge to resection. In published literature, tumor size range from 10-20kg however tumors weighing 18kg and more remain quite rare. Surgical resection is the principal form of treatment, however in large tumors this is frequently difficult due to adjacent vital structures. Consequently, many patients develop local recurrence. Proposed methods of reducing recurrence include adjuvant radiation and chemotherapy.

Although achieving R0 resection margins was the initial goal, in this case it was deemed impossible due to the tumor's adherence to surrounding structures. Preoperative radiation or chemotherapy was thought to be ineffective in this case due to its large size but post-operative chemotherapy may be indicated. The patient's anemia also precluded a more aggressive resection.

QUESTIONS FOR DISCUSSION:

1. What methods can be used to decrease the risk of recurrence?
2. What methods can be suggested to manage a surgical patient who refuses blood transfusions?

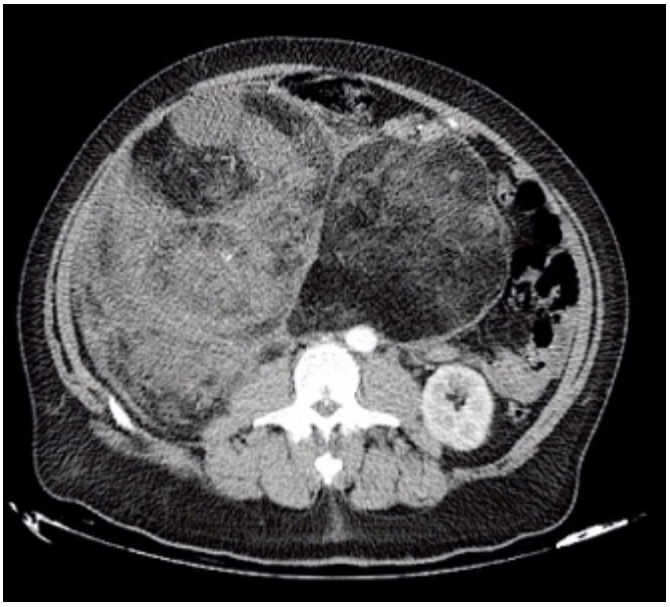

Figure 1: CT scan showing a large heterogeneous lesion with areas of fat and solid densities, occupying the entire abdominal cavity

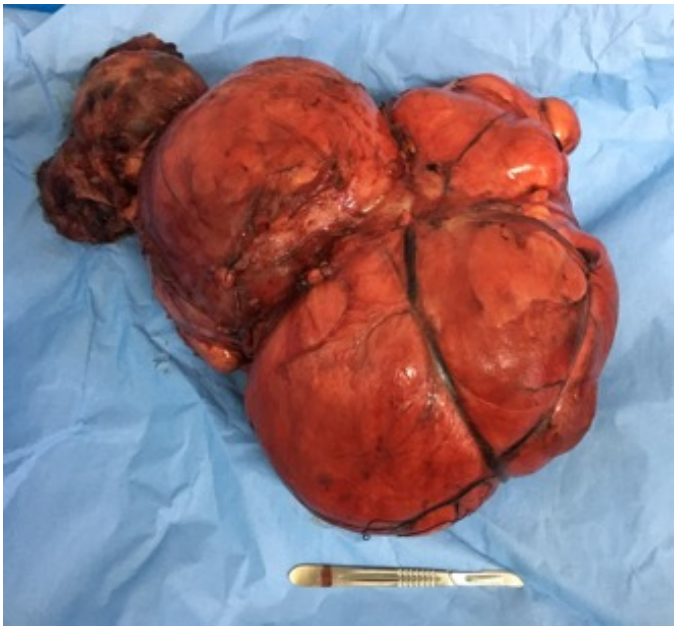

Figure 2: Giant Retroperitoneal Liposarcoma after excision weighing 18kg

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Paper Submission

Session 3

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Paper Submission

Holospinal Epidural Abscess: an unexpected find?

Haralsingh, A, Calderon C, Baggan. K, Ramnarine D

Introduction: Spinal epidural abscesses present infrequently in surgical practice resulting in neurological morbidity, and mortality. A rare find is the presence of an abscess involving the entire cervical, thoracic and lumbosacral regions of the spine, with less than ten (10) reported cases in literature. When this is encountered urgent neurosurgical intervention is required to improve patient prognosis.

Case Description: A 58-year-old, poorly controlled type II diabetic male, presented with a 3-week history of lower back pain and progressive limitation in ambulation. Further deterioration was observed in-hospital, with a sudden decline in power of the lower limbs from Medical Research Council Grade 5 to 2. This prompted urgent magnetic resonance imaging of the whole spine, which depicted an epidural abscess extending from the cervical vertebrae - C3, to the sacrum - S1, with resulting compression of the spinal cord. An emergency multi-level laminectomy was performed with drainage of the epidural space. There was resolution of his sensory deficits and objective improvement in power of the lower limbs post-operation. Culture reports showed the culprit organism to be Escherichia coli.

Discussion: Severe back pain in the diabetic patient requires careful assessment and monitoring. Emergency surgical decompression within 72 hours of neurological symptoms improves prognostic outcomes in patients with spinal epidural abscesses. We contend that performing a multi-level laminectomy procedure is the best option for extensive posterior spinal epidural abscesses without bony involvement. Other methods such as image-guided percutaneous drainage, catheter procedures and intermediate level fenestration procedures, while less invasive, may be more likely to fail.

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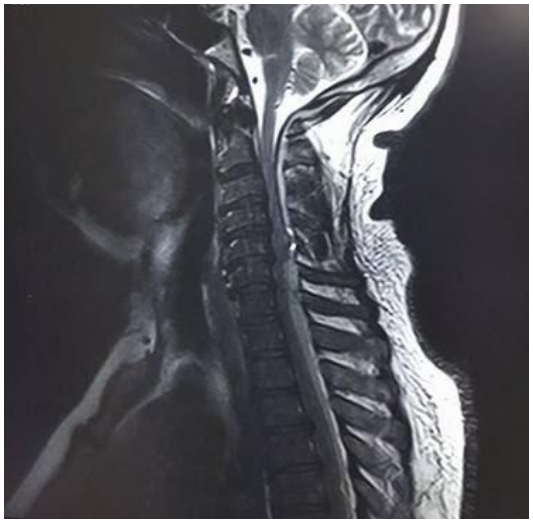
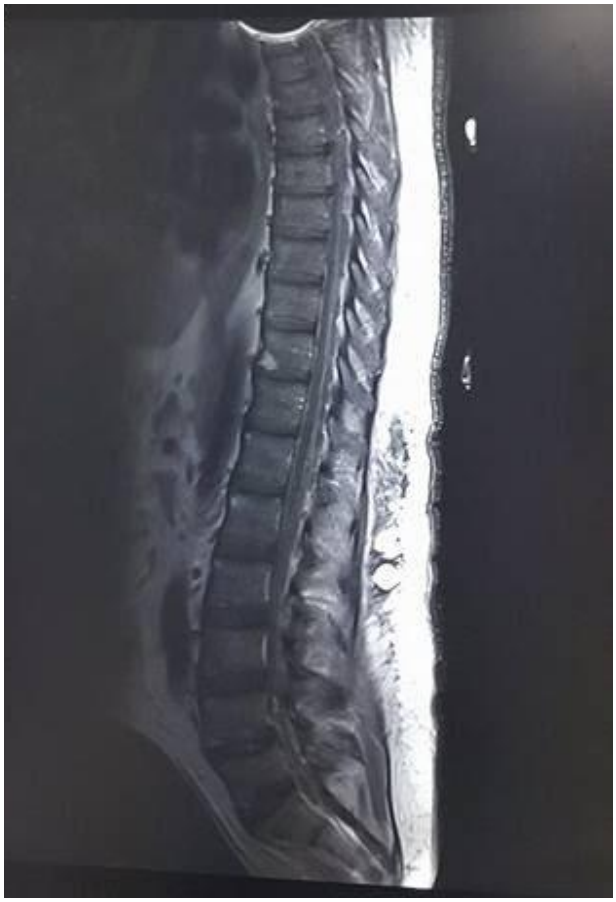
Paper Submission





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National Grand Rounds 2017

Paper Submission

A mysterious retroperitoneal mass.

Mohammed S, Singh Y, Kurvilla T

Introduction: Teratomas are nonseminomatous germ cell tumours that arise from abnormal development of pluripotent and embryonal germ cells. Accounting for only 4% of all primary teratomas, retroperitoneal lesions are rare and more common among children than adults. We report an unusual case of a large primary retroperitoneal mature cystic teratoma in a 28-year-old woman.

Case Description: A twenty-eight-year-old woman presented with a ten-year history of a vague left sided abdominal swelling patient was referred to our clinic for further investigation. Her physical examination was unremarkable except for a firm, non-mobile fullness palpated in her right upper quadrant of the abdomen.
A Computed Tomography Scan was performed that revealed a large, predominantly fatty density, well circumscribed, mass within the upper right retroperitoneum displacing the liver, pancreas and bowel. An exploratory laparotomy was then performed. A 16 cm x 13 cm mass that contained teeth and hair was sent to the pathology department for further evaluation. The patient was discharged and follow up is currently at the surgical outpatient clinic.

Discussion: Primary retroperitoneal teratomas in adults are very rare (1-11% of all primary retroperitoneal neoplasms) and to date, only a few cases have been reported in the literature. The incidence of retroperitoneal mature cystic teratomas peaks twice in the first 6 months of life and in early adulthood. Primary retroperitoneal teratomas are even more rare with only 10–20% of these tumours occur in adults older than 30 years of age. Thus, this diagnosis is a very rare entity.

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Paper Submission

A rare case of trans-articular migration of cerclage wire

Augustus M., Beharry A, Quan Soon C

Introduction: Tension band and cerclage wiring are routine procedures for repair of patella fractures and tendon injuries about the knee. Hardware breakage is a common complication with migration being a possibility. Six case reports in the literature have discussed wire migration, with three of these involving intra-articular translocation of a wire fragment.

This case will illustrate one such missed complication which could have potentially injured vital structures.

Case :A 45 year old man underwent repair of a ruptured quadriceps tendon with cerclage wire. He was lost to follow up but returned to the outpatients' clinic eight years after the fixation with complaints of knee and calf pain, but normal ambulation. The knee examination was unremarkable but a wire fragment was palpable in the calf.

Radiographs showed the broken cerclage wire and migrated fragments lateral to the tibia and in the proximal calf. All of the wire fragments were removed electively.

Discussion : Hardware failure resulting in wire migration has not been well described. Age, high activity level of the patient, poor surgical technique and improper placement of wires can increase the risk of these complications.

Patients with broken cerclage wires should be assessed thoroughly as vascular injury and venous migration of wire fragments to the heart have been documented.

There is no consensus to the timing and follow up protocol in hardware failure, making it difficult to prevent errant wires from injuring vital structures. Is routine removal of all fixation wires therefore essential?

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Paper Submission

Pyrexia of Unknown Origin: 'Surgical Fever"

Ramnarine I, Teelucksingh S, Singh Y, Ramnarine M

Introduction: Mediastinal masses whether benign or malignant are usually incidental findings on imaging as more than 40% are asymptomatic at presentation. Symptoms when present are due to either mediastinal mass effects or systemic effects. This scenario presents a diagnostic dilemma to clinicians and hence surgical biopsy still remains the most important tool in diagnosis.

Case Presentation: A 49-year-old Trinidadian man of African descent, with no significant past medical history, presented with complaints of fever, conjunctivitis and retro orbital pain for six (6) days. He was previously treated 2 weeks prior for a urinary tract infection by a primary care physician. Examination concluded enlarged right inguinal lymph nodes. Routine laboratory studies were unrevealing with the exception of an elevated C-reactive protein and lactate dehydrogenase levels. Leptospirosis, Chikungunya and dengue titres were reported as negative. CT scan which revealed a minimally lobulated, non-enhancing soft tissue density measuring 1.8cm x 1.0cm in the anterior mediastinum, in a thymic configuration, suggesting thymic hyperplasia. A lymphoma, thymoma, thymic hyperplasia and tuberculosis infection were considered as a diagnosis at the time. A lymph node biopsy proved futile. Patient was reevaluated with a CT showing an increase in the size of the mass. The patient was referred to a thoracic surgeon who decided on excisional biopsy via VATS en block thymectomy.

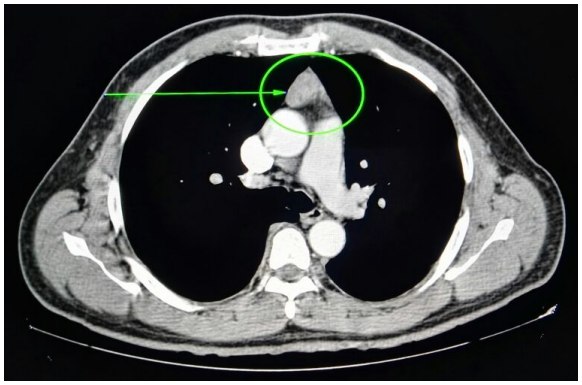

Figure 1: CT scan showing anterior mediastinal mass

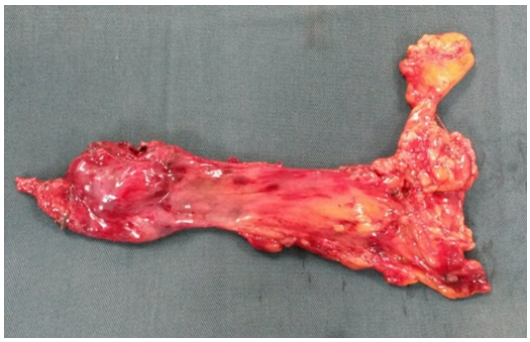

Figure 2: Specimen tube & incision

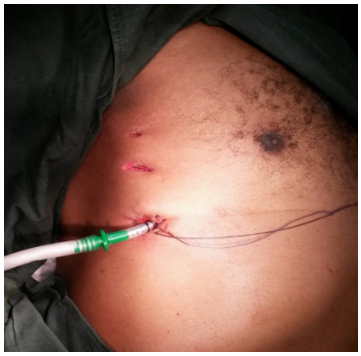

Figure 3: Post-operative chest

Discussion: Tissue biopsy vs Excisional biopsy

Complete surgical resection (R_0) is the preferred treatment for thymomas and is the main factor predictive of survival. The decision to do tissue biopsy when an anterior mediastinal mass is clearly resectable can be difficult. VATS thymectomy is minimally invasive, associated with fewer complications and facilitates faster recovery, hence, it is gaining popularity and is supported by several studies as being superior to the traditional sternotomy approach.

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Paper Submission

McKeown Oesophagectomy

Arra A, Jugool S, Dan D

Introduction

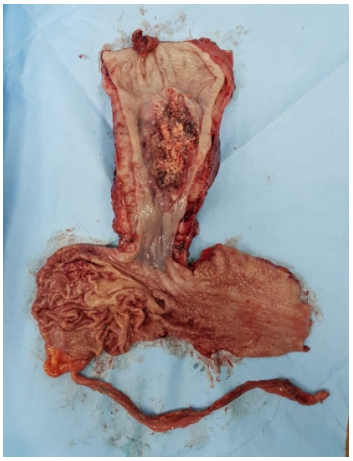
The management of oesophageal carcinoma continues to be a topic of much research and debate. While there is universal acceptance that surgery in combination with systemic or radiotherapy is appropriate, the optimal timing and duration of these therapies can vary among institutions. The extent of surgical resection needed to achieve a good outcome also lacks consensus, with various arguments made for and against more radical surgical procedures.

Case Description

This is a case of a 52-year-old male patient who presented to us with a 2-month history of dysphagia, associated with constitutional symptoms. He had previously undergone a laparoscopic Heller's cardiomyotomy 2 years prior for achalasia. Upper GI endoscopy revealed a friable mass at 35cm from the incisors, which was biopsied to reveal a squamous cell carcinoma. His stage was established on CT as T2N0M0. He subsequently had a McKeown oesophagectomy performed using a gastric conduit, with an uneventful recovery. Pathological assessment revealed a T3N0 tumour, with involvement of the posterior margin, and he was referred for adjuvant chemoradiation.

Discussion

The current controversies surrounding the management of oesophageal cancer have resulted in the implementation of individualized protocols by different institutions. Ours is a unique situation, in which we must often tailor our approach to align with the availability of our resources. In this case we opted for surgical excision followed by adjuvant therapy, and were able to demonstrate a good surgical outcome despite being a low volume institution.



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Paper Submission

Not just another lump. Case report of a Malignant Peripheral Nerve Sheath Tumour.

Moonsie R, White K

Introduction:

Malignant peripheral nerve sheath tumours (MPNSTs) are rare, aggressive, locally invasive soft tissue sarcomas accounting for up to 10% of all sarcomas. The incidence of sporadic MPNSTs is low, with a lifetime risk of 0.001% while in association with the familial condition neurofibromatosis type 1 (NF1) the incidence is 2-5 %. Currently surgery is the mainstay of management.

Case Description:

NM a 35-year-old female presented with a six-month history of an intermittently painful lump to the left forearm. A clinical diagnosis of a lipoma was made and she underwent elective excision of the lump under local anaesthesia but had already defaulted when the histology was reported as a MPNST. Within three months she returned with recurrence of the lump. MRI confirmed a forearm lesion consistent with MPNST, and new lesions in the distal arm. USS guided biopsy of the new proximal lesions in the distal arm were reported to be of benign lymphoid origin. She underwent excisional biopsy of the proximal arm lesions and wide local excision of the recurrent lesion. Histology confirmed negative circumferential margins with deep margin clearance <2mm. Further excision to the tumour bed was done and a split thickness skin graft placed over the wound.

Discussion: How is recurrent MPNST managed?

MPNST is an aggressive uncommon sarcoma. As it is chemotherapy insensitive, surgical resection with negative margins remains the primary management with adjuvant radiotherapy serving to improve local control. Even with this approach the prognosis is poor with tumour size and recurrence serving as negative prognostic factors. Local recurrence is common as is metasta

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Paper Submission

Unintentional Resection of Intra cerebral Metastases

Thornton A, Ramcharan Gosine R, Ramcharan W

Introduction; Case of a patient with assumed synchronous tumors. Radiological assessment indicated likely histologically distinct masses. However, intra and postoperative histopathological assessment confirmed a primary with metastatic spread.

Case Description: A 72 year old male, presented with altered mental status and slurred speech. CT Brain revealed a Left Fronto- Temporal mass. Subsequent admission and work up for possible primary vs metastatic intra cerebral lesion ensued.

MRI Brain - Likely left sphenoid wing meningioma

CT C/A/P - Right upper lobe lung mass, multiple cystic liver lesions

Thoracic surgical consultation at EWMSC was requested. Patient assessed as having Stage 2 Lung Ca with quoted five-year survival and low metastatic potential.

Recommendation of resection of intra cerebral lesion was made, followed by formal Lung Ca work up in EWMSC.

Patient underwent resection of solitary intra cerebral tumor. Intra operative frozen section revealing small cell elements of likely lung origin. Diagnosis was confirmed by the official histopathology report.

Subsequently, patient assessed as Stage 4b small cell lung Ca and referred to National Radiology Center for evaluation and further management.

Discussion

1. Is this a case where adherence to the principle of Occam's razor may have been more beneficial to the patient?

Synchronicity of tumors at presentation is well documented but a rare entity in comparison to prevalence of diagnosis with metastatic cancer.

2. Should have a less invasive biopsy been preformed?

Radiological assessment endorsed two histologically distinct tumors. Ascribed by the solitary nature, location and apparent larger size of the intracerebral lesion.

3. Would greater cohesion of resources provide a different outcome?

Limited resources are an important factor. Patient transfer to another institution without access to patient images and files. Reporting of the MRI and staging CT's by different radiologists cannot be discounted.

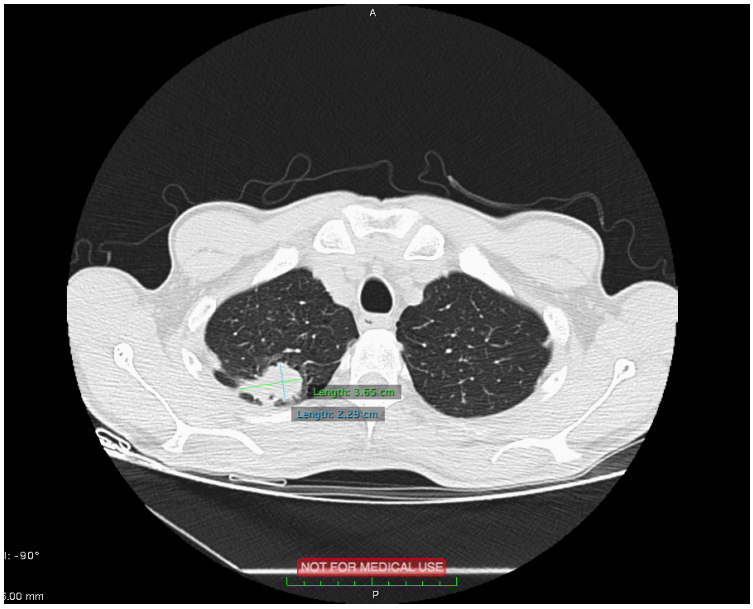
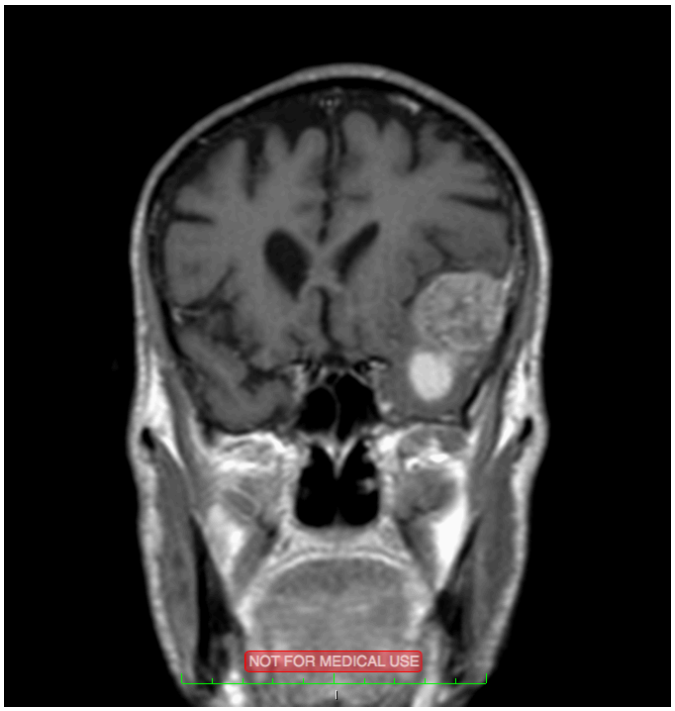


Figure 1: Right Apical Lung Mass

Figure 2: Left temporal tumor



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Paper Submission

Blunt Cardiac Rupture

Arra A, Singh Y, Cawich S, Ramlakhan S

Introduction

Blunt cardiac rupture is defined as a full-thickness laceration of the myocardium. They are rare injuries that are reported to occur in 0.007% to 0.45% of patients who present to hospital alive after sustaining blunt chest trauma. Because of their rarity and obscure clinical presentations, these are notoriously fatal injuries.

Case Description

We report the case of a patient who survived after presenting to the emergency room with blunt cardiac rupture. On admission he was tachycardic and hypotensive, with a left sided haemothorax that drained 1600mls of blood on chest tube insertion. He underwent emergency thoracotomy and repair of a full thickness laceration at the right ventricle. Despite developing a lower respiratory tract infection post-operatively, his recovery was uneventful.

Discussion

Blunt cardiac rupture is usually a fatal injury, with most victims exsanguinating before they arrive in the emergency department. A literature review between 1957 and 2017 revealed that there were only 15 reports ofpatients surviving after sustaining blunt cardiac rupture in the past 60 years. We believe the details of this case can be used to enlighten first responders to the injury patterns and presentations involved in such injuries, which can lead to earlier diagnosis and prompt surgical intervention.

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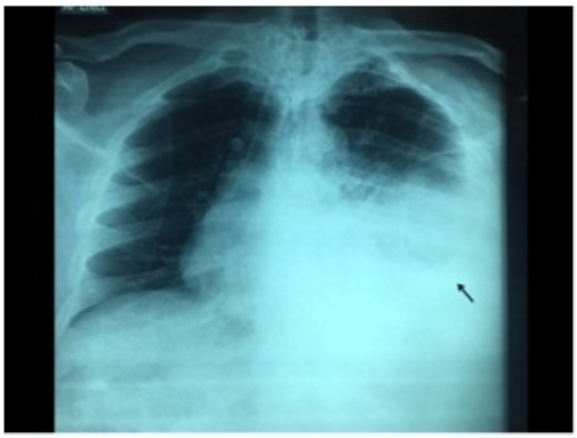
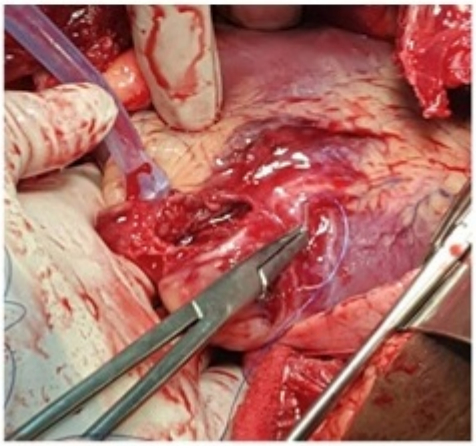
Paper Submission





Plain chest radiograph demonstrating a large left-sided haemothoraxOperative view at thoracotomy during cardiorrphaphy. The suction tip is placed within a 4cm full-thickness, jagged laceration at the right ventricle.