

Carotid endarterectomy without angiography: our experience

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Objective: The aim of this study was to determine whether duplex ultrasonography alone can replace carotid arteriography for the detection of patients suitable for surgery at our department. *Materials and methods:* During a 24-month period 100 patients underwent a surgical cerebral revascularization on our department. The average age of the patients was 72 (34-83). All the patients were submitted a complete duplex ultrasonography for evaluate entity of stenosis, presence of fresh trombus, presence of ulcerations/wounds, extensions of atheroma. When these tests provided information adequate to the entity of the stenosis and on the extension of the atheroma, we deemed them sufficient for the choice of the only diagnostic procedure (38 cases). In the remaining cases, included those which had highlighted interpretation doubts on the ultrasonographic test, we proceeded with angiography. All patients were submitted to a treatment of revascularization with endarterectomy: in 70 cases with an eversion technique and in other 30 cases with application of patches. *Results:* We have not registered post-operative mortality. In the 38 cases without preoperative angiography, the major complications were stroke in one case (2.6%). Minor complications were: transitory paralysis of the superior laryngeal nerve in 1 case (2.6%). In the 62 treatments carried out after the angiography, the major complications were: stroke in one case (1.6%), IMA in one case (1.6%). The minor complications were limited to a transitory superior laryngeal paralysis of the superior laryngeal nerve in one case (1.6%). *Conclusions:* Utilising high resolution ultrasonography it is possible to determine endoluminal and parietal characteristics of the vessels under examination, the emodinamical effect produced by stenosis, the identification of anomalies or miointimal expan-

sions, the consistency of the plaques, the ulcerations are all characteristics which have only rarely or never highlighted by angiography. Therefore, the use of angiography can be today limited to the cases in which is met a suspected presence tandem lesions or difficult individuation of the limit of extensions the carotid atheroma.

Temporary and permanent post-thyroidectomy hypocalcemia in elderly

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Introduction: Temporary and permanent hypocalcemia are possible post-thyroidectomy complications. The aim of this paper is to value predictive risk factors to the development of post-thyroidectomy hypocalcemia in elderly, through 7 years personal experience review. *Materials and methods:* From January 1997 to December 2004 at Surgery Department of "Federico II" Hospital of Naples 97 patients underwent operation for thyroid disease. They were 64 females and 33 males with an average age of 67.5. Calcemia was tested in all patients daily for the first three days after operation. Patients were divided by groups on the ground of operation extension: lobectomy (l), lobectomy with contralateral enucleoresection (l+e), subtotal thyroidectomy (st), total thyroidectomy (tt), total thyroidectomy with lymphadenectomy (tt+ln). We compared hypocalcemia incidence between the following groups of patients, on the ground the operation they underwent. This statistical study has been carried out both for temporary and for persistent hypocalcemia, through Chi Square and Fisher's exact tests, with $p=0.05$. *Results:* We found 34 (10.7%) hypocalcemia cases: 9 were definitive and 25 temporary. All cases were in both thyroid lobes extended operations. Comparing malignant vs benignant diseases we found

20.2% hypocalcemia cases in cancers and 9.2% in benign diseases. Both persistent and transitory hypocalcemia incidence was higher in patients with hyperthyroidism than in euthyroid diseases. We didn't find a statistically significant difference in hypocalcemia incidence, between patients who underwent operation for cancer and those for benign disease. *Conclusions:* We can conclude that hypocalcemia risk factors after thyroidectomy are hyperthyroidism and traumatic injuries caused by both lobes manipulation. Limitation of resection doesn't reduce hypocalcemia risk factor. So to reduce hypocalcemia risk factors it is indispensable to minimise thyroid manipulation until parathyroid glands have not been localised.

The post-operative antitrombotic prevention with physical headmasters in elderly patients

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Study's aims: The antitrombotic prevention with physical headmasters turns out necessary, above all in elderly patients and behaviours, but evaluating the timing of every single preventive therapy well is necessary, since these can turn out ineffective and then useless if you practise in moments make a mistake and with methodical wander. *Materials and methods:* What have been physical methodical holds in the principal one exam of antitrombotica prevention physical therapy, the elastocompression and the pneumatic compression. Have been compared the various characteristics, the advantages and the disadvantages, the effectiveness and above all, the physical headmasters' ineffectiveness when is applied in wrong moments of the post operative in the elderly subject. Turned out obtained: pointed out results the principal ones' methodical uselessnesses of antitrombotica prevention in the post operative of the elderly subject, if they are applied in way and wrong due of time physical therapy turns out of some effectiveness only during the sitting, leaving remarkable time "uncovered" spaces in which the antitrombotica prevention is absent. The immobility to bed of the patient limits the action of the elastocompression which only turns out effective if taken by active muscu-

lar movements, while the intermittent pneumatic compression turns out the choice therapy during the surgical intervention when the "muscular pump deficit" is absolute and the alterations of the vis to back and the vis against make concrete the risk to develop the trombotica illness. *Conclusions:* Therefore one thinks that an only ideal technique does not exist for the antitrombotica prophylaxis with physical headmasters, but that these go chosen in function of the knowledge of emodinamic in way which are direct in aimed way on the fisiopatologic mechanisms which at that specific moment increase the risk by developing the tromboembolica illness. Therefore one considers that the elastocompression finds his choice indication in the post operative period when the patient can perform active movements with the possible one as aid of physical therapy and the passive gymnastics, while instead the intermittent pneumatic compression is the methodical only one which up to now has shown a real effectiveness on the venous return during the surgical act.

Gastro-intestinal angiodysplasia and multiple myeloma: description of a case and review of the literature

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The decision to study this association stems from the case of a 73-year-old female patient with multiple myeloma who came to our observation following several days of fatigue and anemia due to loss of black tarry stools (melena). Esophagogastroduodenoscopy revealed non-bleeding angiodysplastic lesions to the duodenum, but did not explain the hemorrhage. A given capsule endoscopy was therefore performed, which confirmed the lesions described above and also evidenced signs of recent bleeding of the jejunum and ileum. Having demonstrated the cause of the melena, the Authors reviewed the literature in search of a possible link between angiodysplasia and monoclonal disease. Though no evidence was found of a direct correlation between the two diseases, it appears that mul-

tiple myeloma may lead to acquired deficiencies in coagulation factors such as Von Willebrand factor. This may cause abnormal coagulation times, as shown in the laboratory exams performed on the patient upon admission. In conclusion, the message the authors wish to convey is that monoclonal gammopathies may indirectly cause angiodysplastic lesions to bleed, causing symptoms of such vascular malformations to become more apparent.

Lupus mastitis: case report

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Lupus erythematosus panniculitis (LEP) is an uncommon entity, which was first described by Kaposi in 1883 (1). LEP occurs in 2-3% of patients with systemic lupus erythematosus (LES) (2). It is more common in women (2:1) (3) and most patients are middle-age. Panniculitis appears before, coincidentally with or after the discoid or systemic lesions of LES (2). Relatively few cases of lupus mastitis have been reported in the medical literature. A 59 year old woman with a remote history of LES presented in 2004 with right breast mass with localized skin erythema and severe pain. Her mammography revealed heterogeneous microcalcifications and her sonography showed a solid mass (about 3 cm). According to the radiologic findings the mass was considered to be malignant. The patient had no clinical or serologic evidence of LES and no history of breast's trauma. She underwent at surgical biopsy; pathologic findings were clearly negative for breast cancer and showed heterogeneous microcalcifications, perivascular and periductal lymphocytic inflammatory cells infiltrates, dense stromal fibrosis consistent with LEP. The patient received adequate immunosuppression which was successful in controlling her disease. The differential diagnosis (4) of lupus mastitis includes breast carcinoma, scirrhous and inflammatory, idiopathic granulomatous mastitis, lymphoma, panniculitis, morphea and localized lipatrophy but the diagnosis is often confounded because of the paucity of data of lupus mastitis.

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Palliation of abdominal emergencies in the elderly

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Objectives: The aim of this study is to clarify the indications to operative and non operative treatment of acute abdomen in patients over 65 years of age, a condition that in itself may represent an independent risk factor to be considered besides the risks inherent in the urgent nature of the illness. *Materials and methods:* By a careful analysis of the literature we tried to establish the real risks of emergency surgery in the elderly. We analyzed the ratio of elective to emergency surgery, the indications to perform emergency surgery, the preoperative clinical status, age as a negative prognostic factor, the role and usefulness of ASA, the indications to palliative care. *Results:* In the elderly there is a statistically significant increase of morbidity and mortality, for a given age, in surgical emergencies compared to elective surgery. The reported morbidity and mortality in case studies rise respectively from 6 to 9% to 26 to 60% and from 2-15% to 20-27%. Preoperative clinical status worsens proportionally with age: hypertension, type 2 DM, cardiovascular and respiratory diseases, chronic renal failure are the most frequently encountered conditions in these patients. Pancreato-biliary diseases, bowel obstruction, gastro-duodenal ulcers, complicated hernias, cancer, acute appendicitis appear to be, in decreasing order, the most frequent causes of acute abdomen in the elderly. There has been disagreement in literature on whether to consider age as an independent risk factor, even thou-

gh more recently it has been suggested that the higher incidence of co-morbidities in this group of patients, rather than age alone, is responsible for the increase perioperative risk. On the other hand, predictive factors for mortality are undoubtedly ASA, the time interval between onset of symptoms and hospitalization, a stoma or palliative by-pass, or a non-therapeutic laparotomy. Palliation may be the use of self-expanding metallic stents in case of distal colonic obstruction or gastro-duodenal obstruction, the creation of a stoma, or the use of endoscopy. *Conclusions:* The goal of surgeons in the treatment of high risk patients who need to undergo emergency surgery is to prolong survival. This goal can be achieved only by careful assessment of patients on a case to case basis, paying particular attention to the multi-factorial nature of morbidity and mortality. Surgical palliation must be reserved to those severe cases (ASA IV-V) that are already in poor pre-operative status

The role of the endovascular procedures in occlusive vascular disease

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Objectives: In these study we retrospectively reviewed our experience of endovascular procedures performed for lower extremity ischemia due stenotic lesions. *Materials and methods:* A total, of 120 procedures were performed by our division between January 2002-december 2004. Of these 85 involved balloon angioplasty. The median age of the patients who underwent these 85 balloon angioplasty was 74 ± 0.5 years old; 70% were male; 40% had a history of diabetes mellitus, and 15% had ESRD. Indications for the procedures included acute ischemia (6 cases), critical ischemia (rest pain, gangrene, or ischemic ulcers in 78 cases), severe claudication (36 cases). *Results:* 45 of the procedures were percutaneous, and the remaining 40 were combined with some type of open procedure. Those performed as an open technique were in combination with a bypass (22 cases) and in combination

with a patch angioplasty (18 cases). Balloon angioplasties were performed of the iliac arteries (40 cases), the superficial femoral artery (29 cases), the popliteal artery (6 cases), the tibial vessels (10 cases). Intraoperative complications included 2 dissections; inability to dilate the lesion adequately (1 case), and rupture of one iliac lesion that underwent open repair. A total of 36 stents are implanted, stents were initially used highly selectively but recently are now being deployed more liberally in the iliac arteries. *Conclusions:* Based on these data, we suggest that balloon angioplasty in association with stent implant are a safe procedure. In general endovascular stents have two potential therapeutic advantages in the arteries: salvage after abrupt postangioplasty closure and reduction of restenosis. In our hands the most successful application of stents has been for the treatment of lengthy dissection planes after successful recanalization in occluded iliac arteries.

Acute cholecystitis in the elderly. Our experience

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Objective: The treatment of acute cholecystitis is still a matter of debate of considerable importance in the elderly also because the mortality and morbidity in this kind of patients are higher than the youth ones. We want to show the results of our surgical timing. *Materials and methods:* Since July 2002 to December 2004 in our surgical department we treated 96 patients suffering from acute cholecystitis, 54 of whom were aged over 70. The group consisted of 52 females and 44 males. Their mean age was 75. Acute cholecystitis was confirmed by clinical symptoms, clinical signs, laboratory tests and US. Within five days of onset of symptoms in 40 cases we used laparoscopic and in 5 open approach. Patients in which the symptoms were present for more than five days were submitted first to antibiotics therapy (synthetic penicillins and third generation cephalosporins) and/or percutaneous cholecystostomy and then to surgical approach, 30 with laparoscopic and 16 with open approach. Five patients were not operable for surgical absolute contraindication (heart failure etc...). *Results:* We needed

to convert only 16 laparoscopic cholecystectomy to open, 8 during the early (20%) and 8 during the delayed (29%). The mean time of hospitalization was of 7.6 days for early approach and 11.6 for the delayed one. There was no higher rate of complications between the two different surgical timings. *Conclusions:* Our experience is important to show that early laparoscopic approach is feasible because the conversion rate and the post-operative morbidity are no higher than delayed laparoscopy or open approach after medical management. Total hospitalisation is significantly shorter and we avoid the complications which may arise with initial medical management so we should consider early laparoscopic cholecystectomy as the gold standard.

Male breast cancer: our experience

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Breast cancer in males is infrequent, accounting for less than 1% of all malignancies diagnosed in men (1). As a consequence of the relative rarity of the disease, less information are available regarding optimal management and outcomes. Data were collected about ten men presented and treated at our unit for breast cancer from January 1992 to December 2002. Mean age at presentation was 62.5 years. The mode of presentation was often a painless palpable mass. Treatment consisted of 7 modified radical mastectomies and 3 simple mastectomies. Histological examination on surgical specimens revealed 7 infiltrating ductal carcinomas, 2 *in situ* ductal carcinomas and a mucinous breast cancer. Lymph node involvement was seen in one patient. 20% of patients were classified as stage 0, 40% stage I, 20% stage IIA and 20% stage III B. Tumors presented mainly with high expression for estrogen and progesterone receptors. Adjuvant systemic chemotherapy and/or antiestrogen therapy in the form of tamoxifen were the treatment most frequently used. Nevertheless, a patient developed a new cancer in the opposite breast three years after surgery and was treated with radical modified mastectomy and adju-

vant therapy. One patient died for breast cancer, while another died for comorbid disease. Male breast carcinoma presents with an older age and a more advanced stage of disease than do women. However, breast carcinoma in men is not biologically more aggressive than in females. Axillary lymph node involvement remains the most important prognostic factor. Probably, the overall survival found in this group is related to the number of *in situ* carcinomas and also the nodal status (N0). Our experience, according to literature (2, 3) suggests that the prognosis of breast cancer in men is comparable to that of women of the same age and stage of disease at diagnosis and treatment is not much different between two sexes.

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Surgical treatment for pancreatic cancer

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Aims: This study evaluates the impact of different treatments on survival in patients with advanced pancreatic cancer treated from 1995 to 2004. *Materials and methods:* Data on 51 patients (30 men, 21 women), mean age 60.3 years, were analysed retrospectively. We included co-morbidities, symptoms, tumor markers, tumor characteristics, operative data and late outcome. *Results:* In 31 patients pancreatic tumor interested the head, in 4 patients the ampoule, in 7 body-tail, in 9 extensively the gland. Final diagnoses showed 58.9% ductal adenocarcinoma, 13.7% mucinous cystadenoma, 13.7% serous cystadenoma, 3.9% insulinoma, 9.8% unspecified forms. The right site lesions were less differentiated. The median tumor size

was 35 mm; left-sided lesions had larger tumors, but fewer node-positive resections. Surgical procedures included: 4 enucleations, 3 distal spleno-pancreatectomies, 3 distal pancreatectomies with spleen preservation, 9 total pancreatectomies and 11 pancreaticoduodenal resections. Seven patients underwent palliative bypass; 7 endoscopic bile duct stenting. Seven patients underwent explorative procedures (5 with laparotomy, 2 laparoscopy). Tumor margin resections were negative in 68.1% cases. There were no intra-operative deaths. Reoperation rate was 3.3%. Post-operative complications included fistula (9.1%), bile leak (3.5%), acute pancreatitis (3.2%), local recurrences (2.1%). Mean operative time was 127 minutes. The median post-operative length of stay was 12.7 days. Blood transfusion occurred in 56.9% cases. In addition to surgery, 37.5% of patients received chemotherapy whereas 26.8% had concomitant chemoradiotherapy. Median survival for patients treated by palliative surgery was 1.9 months, by chemotherapy was 9.4 months whereas median survival for patients treated with concomitant chemoradiotherapy was 7.8 months. Four patients were still alive at the time of the analysis (11.1 months). *Conclusions:* Pancreatic resection remains the only hope in patients with adenocarcinoma of the pancreas. Adjuvant chemotherapy has shown to improve survival when compared to adjuvant chemoradiotherapy.

Colon bleeding angiodysplasias: efficacy of endoscopic treatment in association with octreotide somministration

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Introduction: Gastrointestinal angiodysplasias are vascular anomalies which are the cause of about the 3,8% of all the cases of digestive bleeding. The treatment of their bleeding remains the greatest clinic problem for the lesions characteristics and the tipology of patients. The therapeutic options are: surgery, endoscopic hemostasis and drug therapy. The purpose of

our study is to assess the efficacy of endoscopic treatment in association with somatostatin analogous. *Materials and methods:* Since January 1993 until December 2003 we observed 36 patients (11 M, 25 F) mean age of 68 years (range 23-86) bleeding from bowel angiodysplasias. Lesions were located at cecum, right colon, sigmoid colon and the whole colon; in 4 cases there were also gastric compromise. All the patients were submitted to endoscopic treatment with electrocoagulation in association with drug therapy octreotide for 6 months and follow up from 5 months to 8 years. *Results:* At the end of our therapy timing we observed a significative increase of Hb levels, the mean was from 6.2 g/dl to 11.7 (p=0.0005); after endoscopic control we documented that the angiodysplasias smaller than 1 cm disappeared and the bigger lesions decrease their dimension and appeared less dark and crooked. During the follow up we recorded a significative decrease of hematic trasfusion in mean from 7.6 to 1.5 units for year (p=0.0005). The bleeding angiodysplasias treatment needed from 1 to 6 sessions of endoscopic hemostasis. There were no complications neither early no delayed after endoscopic treatment and we never saw octreotide resistance. *Conclusions:* The endoscopic treatment in association with octreotide somministration is a sure and usefull therapy of the bleeding colon angiodysplasias. The association of the two treatments obtain a better control of the acute fase and better delayed results. The endoscopic hemostasis with APC seems more sure and needs a less number of tretments than diatermocoagulation.

The breast cancer in the elderly patients

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The cancer is often a geriatric disease and there is a questionable inclination to avoid the curative surgery in the elderly patients. According to recent demographic dates, the senile population is increasing and because of the greatest solid tumours appears during the old age, there is a great interest and attention to elderly patients. We must to establish a conventional

beginning of old age: in the USA is 65 years old, in the Europe is 70 years old. But the biologic conditions rather than the private dates are the guide for the surgeon. The choice of a surgical treatment follows the oncologic surgical guide lines applied with major severity for the peculiarity of elderly patients. In order to a correct antineoplastic treatment we must consider the "Geriatric Assessment" (Functional conditions, Comorbidity, Knowledge and Emotional state, Home and social supports, Nutritional state and Pharmacological therapy). We think that surgical treatment of oncologic elderly patients must respect these important parameters: Performance status, Comorbidity, Expected complications, Life expectation, Patient will, Clinical benefits and Life quality. In order to achieve oncologic radicality, the cancer treatment is based on a correlation between oncologic surgeon targets and biologic conditions of elderly patients: if the performance status is good it is right "best surgical treatment".

Surgical procedures for ulcerative colitis: our experience

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Introduction: Restorative proctocolectomy with ileal-anal anastomosis has become the treatment of choice for patients affected by ulcerative colitis (UC) and familial polyposis. The aim of this procedure is to remove colonic and rectal mucosa, target of the disease, and to maintain gastro-intestinal continuity and transanal defecation. *Materials and methods:* The surgical procedures were performed in unresponsive patients to medical treatment (5-ASA, steroids and immunosuppressive drugs). In the total proctocolectomy, mucosectomy was sometimes carried out through an abdominal approach by means of scissors and Ligasure®. In every case a 12-15 cm long J pouch was confectioned. The ileal pouch-anal anastomosis (IPAA) was performed by transanal approach with the aid of Lone-Star retractor or, according to the "Double Staple Technique" (DST) after insertion of a 31 mm circular EEA. At the end of each procedure a loop ileo-

stomy was carried out. *Results:* between 2002 and 2005 eleven patients underwent IPAA (M:7; F:4; mean age 41.6±2.82; range: 32-54 yrs). In four cases (36%) a hand-sewn IPAA through transanal approach with mucosectomy starting at the dentate line was carried out; in 63.6% (7/11) the DST was performed. There was no intra or postoperative mortality; no septic or major complications were observed. Two (18%) pouchitis were found and successfully treated with 5-ASA and metronidazole. One (9%) hand-sewn IPAA had to be dilated because of stenosis. In one case (9%) after DST, a J pouch had to be excised and advanced because of reappraisal of the disease on the residual rectal epithelium. *Conclusions:* Several controversies still exist regarding the need of whether performing a complete mucosectomy and an ileal-anal hand-sewn anastomosis or utilizing a "double staple technique". According to several Authors, the latter would be burdened by a lower rate of septic complications but by a higher rate of dysplasia of the transitional epithelium. Another debated point is the need of confectioning a diverting ileostomy which, according to several opinions, results to be a fundamental step of this surgical procedure.

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Intraperitoneal partially absorbable mesh for incisional hernia repair in elderly patients

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Introduction: Surgical treatment of primary and recurrent incisional hernia has greatly developed in the last few years, due to the employment of posthetic meshes, which strongly reduced the recurrence rates and due to laparoscopic approaches. *Materials and methods:* In our surgical unit, incisional hernias were treated according to Rives-Stoppa technique utilizing Marlex mesh fixed with metal agraphes in retromuscular/preperitoneal site. In our recent experience we employed an Ultrapro® mesh fixed with fibrin glue.

Results: One hundred-twelve incisional hernias, 86 primary (M:31; F:55; mean age 60.4±9.44 yrs; range: 29-82 yrs) and 26 recurrent (M:10; F:16; mean age 62.1±12.3 yrs; range: 39-85 yrs), have been treated. Overall, 37 patients were older than 65 years. Mean hospital stay was 6.7±3.4 and 6.7±3.1 days for primary and recurrent incisional hernia respectively. In the primary group were observed 11/86 (12.7%) seromas, 5/86 (5.8%) hematomas and one sinus. No seroma or hematoma has been found in the ULTRAPRO® group. Recurrence rate was 3.4%. In the recurrent group, 4/26 (15.3%) seromas, 1/26 (3.8%) hematomas and 2/26 (7.6%) recurrences were observed. **Discussion:** The employment of synthetic meshes for the treatment of incisional hernia is, to date, a widely accepted practice. Several types of meshes, with different composition and structure (pore size, width, etc.) are now available. Ultrapro® mesh is a composite mesh (poliglecaprone-25 and polypropylene) which provides the advantage to reduce the implanted permanent mass to 40%; its structure made by thinner filaments creates a macroporous structure which results to be more susceptible to "tissue ingrowth". Such mesh represents, to our opinion, a balanced compromise between rigidity which allows an easier mesh implantation, and flexibility which provides an anatomic dynamic allocation. The fixation of the mesh through a fibrin glue, furthermore, allows a quick and homogeneous adhesion of the prosthesis, so avoiding wrinkling, reducing the incidence of seromas and hematomas and the need of sutures and metal agraphes which could result, in our opinion, in a lower incidence of postoperative pain.

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Cardiologic risk in patients over 75 years of age undergoing pulmonary resection

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Aims: Cardiocirculatory function testing is a fundamental part of patient work-up prior to pulmonary resection, particularly in individuals at risk (age >75 years or with cardio-respiratory deficiency). This study aimed to assess the incidence of cardiac complications in patients aged over 75. **Materials and methods:** In the last 5 years, 457 patients underwent pulmonary resection due to NSLC. The patients were divided into 2 groups: Group A: 280 patients aged between 65 and 75 (15.7% of the population (n=44) presenting with underlying heart disease). Group B: 65 patients aged >75 years. (58.4% of the population (n=38) presenting with underlying heart disease). All the patients were examined clinically and given a basic ECG with supplementary exercise test in the case of ischemic heart disease. The electrocardiogram was performed in the patients in Group A who were candidates for a pneumonectomy, and in all the patients in Group B. Patients with increased pulmonary resistance or significant coronary deficiency were subsequently given a Myocardial Scintigraphy or Angiocardi-scintigraphy. Lastly, the high cardiac risk patients with respiratory functionality were catheterized. **Results:** In Group A we detected 26 patients (9.2%) with arrhythmia: 18 (69.2%) atrial fibrillation (7 with previous atrial fibrillation), 5 (19.2%) atrial flutter (2 with previous flutter), 3 (11.6%) extrasystole. In Group B we detected 23 patients (35.8%) with supraventricular arrhythmia: 15 (65.21%) atrial fibrillation (8 patients with previous arrhythmia), 5 (21.8%) atrial flutter (1 with previous flutter), 3 (13%) extrasystole. One patient in Group B died post-operatively due to AMI. In Group A the incidence of supraventricular arrhythmia was 68% after pneumonectomy, 18% after bilobectomy, 11% after lobectomy and 3% after atypical resection. In Group B the incidence of supraventricular arrhythmia was 58% after pneumonectomy, 12% after bilobectomy, 15% after lobectomy and 15% after atypical resection. We did not detect differences in survival among the cardiac complication patients with respect to the controls. **Conclusions:** Atrial fibrillation was the most frequent cardiac complication; it was reversible in all patients who did not have arrhythmia prior to surgery. Important risk factors are: age, pre-operative heart disease, extent of the pulmonary resection, surgical procedure (opening of the pe-

ricardium, damage to the vagal nerve, compression of the atrium and pulmonary veins) and shifting of the mediastinum towards the side of the pneumonectomy.

Dialog between the surgeon and the geriatric patient in the process of informed consent to diagnostic or therapeutic procedure

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In Italy, doctor-patient relations are changing: patients no longer stand in awe of the medical profession, and physicians no longer treat patients paternalistically. Opposing needs have evolved into a delicate balance:

- the physician is free to design an informed consent process independently, but always with total honesty and in a way that will safeguard his or her professional authority and dignity;
- the patient is free to determine whether to accept or refuse the procedure(s) designed to safeguard his or her health. The process of informed consent brings these two parties together and, barring compulsory treatments and emergency situations of a health- or life-threatening nature for patients unable to indicate their refusal, envisages consent being given to diagnostic or therapeutic procedure(s).

In medicine, informed consent is what distinguishes the illegal from the legal. It is based on comprehensive and detailed patient information, a balanced assessment of the relevant diagnostic or therapeutic procedure(s), and the patient's clear/unambiguous/manifest decision, provided the patient is legally and medically capable of such a decision. Acceptance of care on the part of the patient should not be passive, but rather the result of a shared decision-making process, with access to those deemed to meet the patient's needs or with the possibility of shouldering the responsibility of refusal.

When the informed consent process involves geriatric patients, it should be noted that although these individuals may not be mentally incapacitated, they may nonetheless be in a state of socio-cultural and psy-

cho-emotional distress, and this may affect their ability to absorb/evaluate/weight information, make choices and express their will. Under such circumstances:

- effective communications through making an effort to ensure thorough comprehension, and adjusting the message to the level of understanding, will be determined by how and what the doctor says in relation to the cultural/cognitive level and psychological status of the recipient. Plain language is advisable, avoiding excessive use of technical or scientific terminology, and conveyed gently, with elements of hope in cases with a serious/poor prognosis;
- the patient's will, though sometimes not readily evident, must be ascertained by the doctor and confirmed by signing the appropriate informed consent form. With these precautions, the physician will ensure the active participation of the geriatric patient and the legal validity of the patient's consent.

Carotid artery stenting in elderly patients: our experience

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Introduction: In the past few years carotid angioplasty and stenting (CAS) has increasingly been used as an alternative to carotid endarterectomy (CEA) for treatment of carotid stenosis and because in this procedure there is no need for general anesthesia and surgical incision the benefit may be especially for those old patients that may not be fit for traditional surgery. We report our preliminary experience with carotid angioplasty and stenting in aged patients. *Patients and Methods:* From April 2003 to May 2005 18 patients aged 80 years and older with high grade carotid stenosis (>70%), detected by ultrasound triplex scan, were treated with CAS at our institution. The indication to CAS was the high grade of operative risk in relation to the age. Of these 18 patients 8 were symptomatic and 10 were asymptomatic. A filter-type cerebral pro-

tection system were deployed in the distal internal carotid artery before the the stent delivery in all patients. In each patient neurologic examination was performed (including the NIH stroke scale) before and after the procedure. All patient were followed by ultrasound study in the follow-up. *Results:* There was no operative mortality and no major stroke in the series. Two patients (11,1 %) suffered transient ischemic attack after the procedure. The mean follow-up time has been 11 months and no evidence of recurrent stenosis has been reported. *Conclusion:* The benefit of CEA were mainly achieved by carefully selecting patients, excluding elderly patients (older than 79 y.o.) and those at high risk for concomitant medical conditions. CAS is evolving as an alternative to carotid endarterectomy because it's less invasive and does not have the risk of anesthesia. A major limitation of carotid angioplasty is distal embolization during the procedure: balloon dilatation, stent implantation and manipulation of the vessel through catheters and wires release embolic debris, which can cause severe damage. Therefore embolic protection devices have to be routinely applied to emphasize the advantage of this less invasive procedure. Nevertheless we had two neurological transient complication in the first period of the experience, probably related to the learning curve. In-stent recurrent stenosis after carotid artery stenting has been reported as a relatively infrequent complication (3.5-4.9%) and up to now we didn't observe anyone.

Day Surgery for the treatment of inguinal hernia: our experience

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Objective: Inguinal hernia is an important and frequent problem in old patients. The aim of this study is to have a complete review of our cases and to evaluate the utility of Day Surgery (DS) in this pathology. *Materials and methods:* Between January 1994 to June 2005 we treated 342 patients with inguinal and femoral hernia (313 males and 29 females), 302 with inguinal hernia (16 bilateral) and 40 with femoral her-

nia. Mean age was 77.2 years (range 70-99). General anaesthesia was performed in 55 cases; the other patients underwent loco-regional anaesthesia. In 77 cases were incarcerated and strangulated hernias; bowel resection was performed in 13 cases; 216 surgical procedures were done using Tendion Free technique. Pre-operative management of DS patients consisted of blood examination, ECG, chest x-ray and in particular cases cardiological and anaesthesiological evaluation. *Result:* All this DS patients arrived to our Center only a few hours before surgery and underwent trichotomy. A single dose of antibiotics was administered. Before surgery, skin was washed with povidone iodine. Two percent carbocaine was used for loco-regional anaesthesia. In the post-operative period the attention was focused on pain control and diuresis. All the patients left hospital approximately 4 hours after operation. On the other side, the patients who underwent general anaesthesia had a medium post-operative recovery of 4.6 days. Mortality rate was 0.74% (3 inguinal and 2 femoral incarcerated hernias). There were not significant local complications. Recurrence rate was 2.15% (4 cases treated with traditional technique). No recurrence occurred in patients treated with tension-free technique. *Conclusion:* In the old patients with inguinal or femoral hernia we prefer to use tension-free technique because it's a safe and simple procedure, without significant complications and low recurrence rate. Moreover DS and local anaesthesia are optimal solution for these old patients that often have associated disease (diabetes, hypertension), there was also good compliance in pain control with lower post-operative analgesic therapy.

Surgical aspect in the treatment of differentiated thyroid cancer in the elderly

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Introduction: Thyroid carcinoma, despite accounting for 1% of all human cancer, are the most common endocrine malignancy. Papillary carcinoma has an excellent long-term prognosis, the overall survival rate at

five years is about 99%. The most important prognostic factor is the patient's age; the most important tumoral factor is the extent of the tumor, the local invasion, the multicentricity and ploidy. There is still some controversy about treatment, total thyroidectomy or conservative surgical excision like lobectomy extracapsularly. In fact clinical experience show similar survival in minimally invasive carcinomas. Complications after thyroidectomy (hemorrhage, hypocalcemia, bilateral recurrent laryngeal nerve lesions) involve the hospitalisation and treatment after surgery. *Methods:* We have examined 600 patients who have undergone a surgery for thyroid pathology in the last eighteen years. 82 patients followed thyroid cancer, 75 differentiated carcinoma, 5 medullary carcinoma and 2 anaplastic carcinoma. There were 52 women and 30 men between 17 and 83 year old. 22 patients were more of 65 years old. We made among differentiated carcinomas (52 papillary and 23 follicular, 0.5-6.5 cm) 55 total thyroidectomy, 15 near-total thyroidectomy and 5 lobectomy. Surgical excision of lymph nodes was functional, selective, monolateral in 10 cases, bilateral in 4 cases. *Results:* We had 1 case of permanent monolateral recurrent nerve paralysis after total thyroidectomy, 4 cases of transitory monolateral recurrent nerve paralysis. In 6 patients there was transitory hypocalcemia and in 2 cases permanent hypoparathyroidism. Median follow-up range from 1 to 15 years; lung metastases occurred in 1 patient with papillary cancer and 1 patient had local regional lymph nodes recurrences. The dismissal was between the 1st and 5th day. *Conclusion:* The prognosis in differentiated thyroid cancer is good; today surgical treatment prefer total thyroidectomy according to prognostic factors also in patients more of 65 years old. Short hospitalisation is effective in reducing the cost of hospital care in selected patients young, without coagulative deficit or altered calcium metabolism.

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Ductal carcinoma *in situ* of the breast in the elderly

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Introduction: Ductal carcinoma *in situ* of the breast (DCIS) present some problems about clinical and radiological diagnosis and surgery. DCIS frequency is about 15-25% of breast cancer; surgical treatment foresee biopsy, breast conserving surgery, mastectomy with axillary dissection. Radiotherapy reduce local recurrence and endocrine therapy is indicated for selected patients. *Material and method:* The Authors report their experience in the last eighteen years about 132 ductal carcinoma *in situ* of the breast. Fiftyfive patients (41.1%) are over 65 years old. Diagnosis was clinical in 22% and radiological in the 78% (microcalcifications, mass or architectural distortion) with fine needle cytology, core biopsy, Mammotome. Breast conserving surgery was performed in 44 patients (80%). In the last seven years sentinel node biopsy was performed in 32 patients; in one patients with SN metastases was performed I and II level axillary dissection. *Results:* In 30 cases (54.5%) histology evaluated comedocarcinoma with 2.8 cm in diameter. Adjuvant radiotherapy was indicated in patients with palpable DCIS, more to 2 cm in diameter, comedo. Endocrine therapy was indicated in estrogen receptor positive tumor. Local recurrence is 8.1%. *Conclusion:* Guidelines for surgical treatment of DCIS are: radiological or clinical diagnosis, tumor's extent, histological classification, grading and margin status. Today we prefer breast conserving surgery with tumor margin's study. The authors report their experience in the last seven years about sentinel node biopsy. Radiotherapy and endocrine therapy are indicated for selected patients; local recurrence after DCIS therapy is 8.1% with a 6.1 years follow-up.

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Obstructive jaundice in elderly patients

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Background: In elderly patients the obstruction of the biliary ducts can be determined by benign or malignant diseases. Usually metabolic disorders and cardiovascular diseases are present in this age and diagnosis and treatment are of major difficulties. **Aim:** To evaluate if diagnostic procedures and therapeutic choices of the obstructive jaundice in elderly patients are modified by clinical and laboratory parameters. **Patients and methods:** From January 2003 to March 2005 were studied 10 elderly patients with obstructive jaundice (5 female; 5 male). The mean age was 72 years old (65-91). The cause of the bile duct obstruction was benign disease (choledocholithiasis) in 6 of patients and malignant disease in 4 (carcinoma of gallbladder in 2, hilar biliary carcinoma in 1, carcinoma of ampulla Vater in 1). In 5 of patients cholangitis was associated. In all patients clinical and laboratory parameters was investigated. Magnetic resonance cholangiopancreatography (MRCP) and endoscopic retrograde cholangiopancreatography (ERCP) were performed. **Results:** In all cases ERCP confirmed the diagnosis of MRCP. The treatment of choice in all cases was endoscopic. Biliary obstruction for choledocholithiasis was normalized after ERCP for spontaneous migration of stones and stones fragments cleared from the duct without procedure – related complication. Cholecystectomy was performed afterwards. In patients with malignant disease was inserted endoscopic stent by ERCP in 3 of the patients and by PTC in 1 patient. The jaundice was alleviated in all cases. No death was correlated and median survival of the patients treated to endoscopic stent was 11 months. **Con-**

clusions: In elderly patients the diagnosis of level and cause of obstruction can be performed by MRCP with elevated accuracy. The treatment of choice for choledocholithiasis is endoscopic so as in young patients. For malignant strictures endoscopic insertion of stents by ERCP or PTC is gold standard when by-pass surgery or tumour resection cannot be performed for morbidity associated. We believe that endoscopic palliation is a safe choice for the quality of life as metabolic disorders and cardiovascular disease may interfere with a more aggressive decision. Moreover metabolic disorders and cardiovascular disease have not modified diagnostic procedures and choice of treatment in this study.

The role of sentinel node biopsy in ductal carcinoma *in situ* (DCIS) of the breast: why map DCIS?

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DCIS of the breast is a heterogeneous group of lesions with diverse clinical presentation, histologic features, and malignant potential. The current treatment of DCIS is breast conservation plus radiation therapy, mastectomy for diffuse lesions, no axilla. An axillary dissection is not required, low incidence of nodal metastasis < 2% and significant morbidity. The role of sentinel biopsy in DCIS is controversial. We perform sentinel node biopsy when DCIS patients:

- palpable or large mammographic mass;
- DCIS requiring mastectomy;
- previous biopsy in which the pathologist “cannot rule out invasion”.

Survival and recurrence after surgery for periampullary tumors

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Aims: Surgery is the mainstay of treatment for patients with periampullary tumors. We report survival and recurrence data in patients undergoing palliative or curative surgery for these tumors, evaluating prognostic factors that could affect survival and disease-free survival in the subgroup of patients who underwent resection. **Methods:** Survival and disease free survival were evaluated in 140 patients who presented with periampullary tumors. Univariate and multivariate analyses were performed on several clinicopathologic variables to determine factors affecting survival and recurrence in the subset of patients treated by resection. **Results:** The overall median survival time was 6 months after by-pass operations and 17 months after resection. The 1-, 3- and 5 year actuarial survival rates after resection were 62.5, 19.6 and 14.2% respectively. The 1-, 3- and 5 year disease-free survival rates after resection were 40.1%, 14.2% and 9.8%. Multivariate analysis identified only a pre-operative bilirubin level over 200 $\mu\text{mol/L}$ ($p=0.02$) as a significant predictor of poor prognosis in patients with pancreatic adenocarcinoma. Tumor differentiation ($p=0.01$) and tumor staging ($p=0.02$) had an independent significant relationship to disease-free survival in patients with pancreatic adenocarcinoma, whereas age over 70 years ($p=0.04$) and lymphatic invasion ($p=0.01$) were found to be significantly related to disease-free survival in patients with non pancreatic periampullary adenocarcinoma. **Conclusions:** Several parameters were found to have an impact on survival and disease-free survival after resection for periampullary tumors. Further investigations are mandatory to clarify the link between these factors and early recurrence in light of a generally dismal prognosis of these tumors.

The outcome of laparoscopic colorectal surgery in elderly patients: our experience

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The increasing proportion of the population aged over 65 has pushed surgeons to find better strategies of treatments in elderly patients, also considering the

high prevalence of co-morbid conditions. Miniinvasive surgery may have a big impact on these patients, although it has not yet been universally accepted. Considering that the incidence of both benign and malignant colo-rectal disease is proportional to age, we retrospectively review our series of laparoscopic colorectal resection (LCR) in patients ≥ 65 years of age investigating the incidence of short-term complications and mortality due to the surgical procedure and presence of co-morbidity. **Methods:** From January 2000 to April 2005 52 patients aged 65 and above (65-82, mean age 69 yrs) underwent LCR. Diagnoses were 21 diverticulitis and 31 colo-rectal cancer Dukes T1-T2-T3. Procedures performed were right hemicolectomy (3), left hemicolectomy (5), anterior resection (29), sigmoid resection (8), Hartmann's procedure (3), abdominoperineal resection (4). Fortysix patients (88%) had at least one co-morbidity (Tab. 1), 11 of 52 were classified as ASA II, 37 ASA III, 4 ASA IV. **Results:** Conversion to open surgery was necessary in 3 cases due to underestimated disease (tumor mass, fixation etc.) 3 for technical error due to learning curve and 1 for endoluminal stappler defect (total 14%). Duration of surgery was 220 min (± 40 min); the length, depending on the type of procedure, has however decreased with experience.. Less bleeding has been noticed during mesorectal excision in 7 patients who underwent neo-adjuvant chemo-therapy. There were no perioperative deaths and no laparoscopic related morbidity. Postoperative complications occurred in 11 patients (21%), 7 ASA III and 4 ASA IV (Tab. 2) which compares favourably with results of open colectomy in ours and other published series. In particular the incidence of pulmonary complications and wound infections is clearly lower. A median hospitalisation in no complicated patients was 9 days which is significantly shorter when compared to many series of open colectomies. **Conclusions:** The results of our short ex-

Table 1. Co-morbidities

Co-morbidities	No patients (%)
Hypertension	39 (75%)
Chronic Obstructive Pulmonary Disease	28 (53%)
Diabetes Mellitus	19 (36%)
Ischemic Heart Disease	9 (17%)
Others	32 (61%)

Table 2. Postoperative complications

Disease/ Surgical Procedure	ASA	Complication
Diverticulitis Sigmoid resection	III	Ileus
Cancer Right hemicolectomy	III	Ileus
Diverticulitis Sigmoid resection	III	Wound infection
Diverticulitis Sigmoid resection	III	Wuond infection
Cancer Anterior resection	III	Heart failure
Diverticulitis Sigmoid resection	III	Urinary retention
Cancer Abdominoperineal resection	III	Urinary retention
Diverticulitis Sigmoid resection	IV	Respiratory insufficiency
Cancer Anterior resection	IV	Respiratory insufficiency
Cancer Hartmann's procedure	IV	Ileus/Heart failure
Cancer Hartmann's procedure	IV	Abscess

perience, if combined with other larger series published, indicate that LCR in the elderly is feasible, safe and well accepted by the patients since it produces less morbidity and is related to a better short-term outcomes reducing the time of hospitalisation with a more rapid return to physical activities.

Inguinal hernia repair under local anaesthesia in elderly patients: results of a prospective study

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The abdominal wall hernias in the geriatric population is a very common pathology due to the loss of strength of the muscular tissue. Elderly patients have a higher risk of post-operative complications because of frequent concomitant pathologies. Besides the surgical procedures also the anaesthetic techniques used has great importance in the incidence of complications. *Methods:* From January 2000 to December 2004 96 patients (>65 years old; range 65-89; mean age 76) underwent elective inguinal hernia repair with "tension-free" technique. 30 patients belonged to ASA II, 43 to ASAIII and 23 to ASA IV. All surgical repairs was performed under local anaesthesia (LA) (mepivacaine 2% + bupivacaine 0.5% + saline or ropivacaina 7.5 mg/dl) following standard premedication. 21 patients

were affected by inguinoscrotal hernia and needed a suction drain; 18 patients presented recurrent inguinal hernia (12 Bassini 6 mesh technique). In 15 cases they showed bilateral inguinal hernia. Cardiovascular, pulmonary, metabolic, and hepatic diseases were the most frequent comorbidity (78%). *Results:* Mean hospital staying was 4.5 days (3-10) 28 patients (29%) were discharged one day after the operation. A total of 35 patients suffered mild/moderate early postoperative pain and needed use of FANS. None of the procedures was complicated by any side-effects due to the anaesthetic technique. No conversion to general anaesthesia was necessary. Neither mortality or major complication have been reported in our series. In 15 (16%) cases we observed local complications consisting of 1 wound infection, 6 scrotal haematomas, 8 subcutaneous haematomas. 17 Patients suffered of temporary postoperative urinary retention. The follow-up time has been 2 years for 66% of these patients. No recurrences were reported, only two cases of persisting pain have been declared. 90% of the patients were satisfied and declared that they would recommend the same anaesthesia to others. *Conclusions:* The results of our study indicate that elective hernia repair in the elderly population is highly worthwhile and appreciated by the patients. The lack of major complications may be attribute to the early mobility and the absence of side effects following LA. Advantages of LA in geriatric patients with inguinal hernia are many and it should be taken in consideration, for the confort of the patient and the low costs.

Morbidity and mortality for total d2 gastrectomy in patients over 70 years-old

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Aim: To determine if the morbidity and postoperative mortality after a total gastrectomy with a D2 lymphadenectomy for gastric cancer performed on patients of more than 70 years of age were different from those of younger patients. *Materials and methods:* Between 1987 and 2004 we observed 413 pz with ga-

stric and cardia cancer. The cases of 52 pz >70 years and 136 pz <70 years-old who underwent to total gastrectomy with a D2 lymphadenectomy for gastric adenocarcinoma were reviewed. *Results:* No differences were observed with respect to patients of a younger age at diagnosis regarding the site of the tumor, extension of the disease, or Lauren's histologic type. The elderly group had a higher ASA risk (III in 76%). All of them had a R0 resection. We observed complications in 5/52 pz (9.6%) in the elderly group, in 20/136 (14.7%) in the younger group (overall incidence of complications 25/188 pz 13.3%), (P not significant). Mortality < 30 days occurred in 5/52 pz (9.6%) in the elderly group (3 with a pregress IMA, 1 with BPCO) and in 8/136 pz (5.8%) in the younger group (P not significant) (overall mortality 13/188, 6.9%). In the two groups, the curability was directly correlated to the cancer stage. *Conclusions:* Gastrectomy for elderly patients can be carried out safely by specialists. In particular cardiovascular risk factors seem play a major role in the over-70-years-olds.

Anaplastic thyroid carcinoma: role of surgery

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Introduction: Anaplastic or undifferentiated thyroid carcinoma (ATC), represents 5% to 15% of primary malignant thyroid neoplasms. ATC occurs mainly in the elderly. The median age of 84 consecutive patients evaluated at the Mayo Clinic from 1971 to 1993 was 70 years (range 43-87 years). Females were affected more frequently than males (F:M = 1.3:1; 57% vs 43%). It is one of the most aggressive solid tumors in humans. Usually, it is quickly fatal, with a mean survival of six months after diagnosis. Multimodality treatment with surgery and/or external beam radiotherapy and chemotherapy are of paramount importance for local control of disease and to enhance survival. *Patients and Methods:* Starting from 1980, 24 patients (15 F and 9 M) have been treated for ATC at our institution. Pts. received the following treatment: Group A (9 pts), surgery followed by che-

motherapy Group B (6 pts), surgery followed by radiotherapy Group C (9 pts), surgery followed by chemo- and radiotherapy *Results:* Group A pts showed a median survival of 5 months, group B pts showed a median survival of 9 months whereas group C pts showed a median survival of 10.2 months ($p < 0.01$). *Conclusions:* Aggressive multimodality (surgery, radiotherapy, chemotherapy) treatment regimens show promise in improving local control in patients with ATC. Nevertheless, survival rates remain low. Despite application of such complicated therapy, no standardized successful treatment protocol has yet been established.

Sympaticectomy vs treatment with PGE1 in a typical older disease: peripheral obliterant arteriopathic disease

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Background: The aim of the study was to compare the effects of two different vasodilatory therapies in the treatment of chronic arterial diseases of the lower limbs, one pharmacological and the other surgical. For this purpose we planned a study based on 86 patients randomly assigned in two treatment groups: in the first group all patients received an infusional therapy based on prostaglandin E1; the second group of patients were submitted to lumbar sympathectomy. *Methods and results:* The patients were randomly assigned to two different treatment groups, after giving informed consent: the first group (A) comprised 40 subjects who were treated for 28 days with therapy consisting in slow infusion (approximately 2 hours) of 40 mg of prostaglandin E1 twice daily; the second group (B), consisting of 46 subjects, were submitted to lumbar sympathectomy, including the 2nd and 3rd ganglion. 24/40 (60%) patients in the group A showed complete remission in response to therapy with prostaglandin E1; 7/40 (17.5%) were partial responders and the remaining 9/40 (22.5%) non-responders. In the 46 patients of the group B

treated by lumbar sympathectomy, we observed complete remission in response to surgery in 29 (63%), while 7 were partial responders (15.2%) and 10 non-responders (21.7%). *Conclusions:* Broadly similar results were achieved with the two types of treatment. Both are indicated mainly in Fontaine stages IIB and III (non-advanced), particularly when revascularizing therapy proves impossible or excessively risky. The two strategies examined can be advantageously combined with direct revascularization surgery and may therefore constitute the first-line approach favouring subsequent therapy.

Carotid endarterectomy under loco-regional anaesthesia: perioperative morbidity and mortality

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Objectives: Cervical carotid stenosis is one of the main causes of ischemic stroke. Carotid endarterectomy is a safe procedure for treatment of moderate and severe symptomatic and asymptomatic carotid stenosis. Loco-regional anaesthesia for carotid artery surgery has many advantages over general anaesthesia. It may be associated with a reduction in neurological, and equally important, non-neurological morbidity and mortality. *Materials and methods:* From January 2002 to December 2004, 128 patients were operated on their carotid arteries. Of these, 116 (90%) patients and 136 carotid arteries were operated on in loco-regional anaesthesia and included in a prospective recording. The patients age ranged from 47 to 100 years (mean 70.5 years), 85 patients were male, 31 female. 45 patients (41%) were asymptomatic (Fontaine stage I), 41 have had a transient neurological deficit (TIA) prior to admission (Fontaine stage II) and 31 patients have had a stroke (Fontaine stage IV). All patients had carotid stenosis over 70%. *Results:* The combined stroke rate was 2.2% (n=3). The overall 30 day mortality was 0.8% (n=1). The rate of haematoma indicating revision was 3% (n=4). The re-

vision in all cases was within 12 hours of surgery. No patient developed respiratory insufficiency after surgery. However, of the 4 patients with revision for haematoma, 1 (10%) needed prolonged respiratory assistance and one patient ultimately died of respiratory insufficiency and stroke. No cardiac mortality was observed. The over all rate of myocardial infarction observed postoperatively was 1.4% (n=2), of which 1.1% (n=1) were non q-wave infarcts. The combined shunting-rate for all stages was 18.6% (n=19). *Conclusions:* Morbidity and mortality of carotid endarterectomy in loco-regional anaesthesia is comparable to recently published single-centre results. Patients with severe COPD, usually unsuitable candidates for general anaesthesia, can also be treated safely. Our results, compared with the literature, show that endarterectomy is a safe procedure to treat moderate or severe carotid artery stenosis.

Endoscopic surgery for treatment of nasal sinus polyposis in elderly patients: our experience

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At present, surgery is the elective treatment for nasal sinus polyposis; nevertheless, on the one hand a meticulous surgery reduces the percentage of recurrences, on the other hand there are cases in which even the most meticulous removal of the entire pathology cannot prevent the reappearance of polypus. Therefore recurrences wouldn't appear so much linked to the type of surgery, rather onset appears linked to intrinsic, only partially recognizable factors responsible for the primary and secondary polypogenesis. In order to find an explanation for recurrences, different researches took into account different parameters (age, sex, severe deviation of the septum causing restriction, turbinate hypertrophy) but all this did not prove to have any significance. The monolateral and bilateral implication of the sinus system doesn't appear significant with regard to this, while ASA and NSAID intolerance and abundant eosinophilic infiltration in the mucous chorion proved statistically si-

gnificant for recurrence. Post-operative topical prophylactic treatment with steroids (fluticasone propionate, mometasone furoate) or antihistaminic drugs (cetirizine, loratadine, mizolastine), did not appear to affect the reappearance of polypus even if it had a positive effect on subjective symptoms. As the pathology tends to recurrence, sometimes patients must face surgery in one's old age, and the endoscopic methodology is surely the most suited to an elderly patient because it reduces the problems linked to surgery. In the light of the latest acquisition about endoscopic functional sinus-nasal surgery, authors describe their experience on this subject.

Usefulness of ultrasound-guided fine-needle cytology in the diagnosis of non palpable small thyroid nodules

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Aims and background: Contradictory attitudes have been proposed for the management of non palpable thyroid nodules. The aim of our study was to evaluate the indications and limits of US-FNC in non palpable infracentimetric thyroid nodules. *Material and methods:* From September 2003 to December 2004 we have considered 325 patients with non palpable thyroid nodules. We have therefore divided our series in 3 groups (according to the diameter of the lesion) to verify the effectiveness of US-FNC for lesions less than 1 cm. *Results:* We considered the cases with satisfactory results and unsatisfactory ones in the three groups in which the sample was divided (from 4 mm to 1 cm; from 10.1 mm to 15 mm and from 15.1 mm to 25.5 mm) to demonstrate there is no significant difference (5%) in the percentage distribution of the unsatisfactory results in the three groups. Our statistical analysis (z-test) demonstrated there was not a significant (5%) difference in the percentage distribution of the unsatisfactory results in the three groups. *Conclusions:* According to our experience it is our impression that fine-needle cytology is considered to be a useful diagnostic help also for nodules less than one centimeter because the percentage of unsatisfactory results is not related to the size of the nodule.

Rare breast tumors in elderly

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Breast cancer represents 30% of all female malignant tumors. Invasive ductal carcinoma represents 80% of these tumors. The remaining 20% consists of other histological types. Some of these rare tumors tend to present in elder patients, compared with ordinary breast cancer. These rare neoplasms present a different clinical management compared to usual breast cancer histotype. This leads to the main role of preoperative and intraoperative histological diagnosis. From December 2003 to December 2004 we performed US-FNC on nonpalpable breast nodules in 305 females. Among these we considered 83 over-65 patients. The cytological diagnosis in this group showed 44 carcinomas: 37 invasive ductal carcinomas, 3 lobular carcinomas, 1 tubular carcinoma, 1 inflammatory carcinoma, 1 metaplastic carcinoma, 1 mucinous carcinoma and 1 metastasis from a signet ring cell gastric cancer. Two main conclusions derived from the clinical analysis of this series. In facing rare breast tumors, usual malignancy diagnostic criteria could not be the same than for typical breast cancer. A clear benign mammographic presentation in an over-65 patient could not exclude a rare breast cancer, as a mucinous or a medullary carcinoma or a metastasis from other extramammary malignancies. Moreover there are not clear indications about surgical and oncological treatment of these rare tumors because of the lack of Randomized Controlled Trials, so that the only "evidence" remains the personal experience of the surgeon.

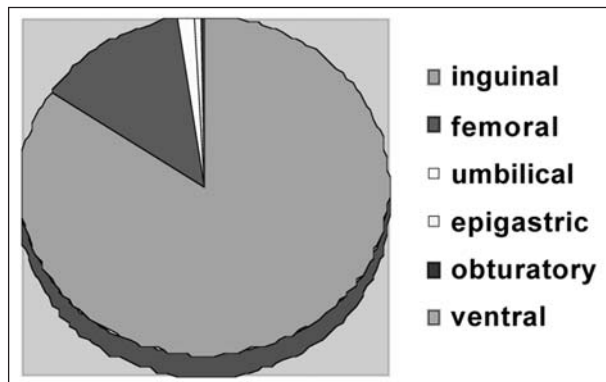
Obturator hernia: three cases report

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They are rare hernias relating to 0,07% and mainly concern females from 70 to 90 years of age. The obturator foramen, situated in the anterolateral wall of the pelvis, delimited by the pubis and by the ischium, is closed by the obturator membrane. It's 3 cm long and it is oblique, inside laterally is the obtu-

Table 1. Operation of hernial pathologies from 1986-2003

Type of hernia	N.	%
Inguinal	1987	84.1
Femoral	320	13.5
Umbilical	34	1.4
Epigastric	16	0.6
Obturator	3	0.12
Ventral	1	0.04
Total	2361	100



ratory nerve which divides into an anterior branch to the mm, pettineo and a posterior branch at the anal cleft. At the centre there are the obturator vessels, the lymph nodules, the adipe, the sac is between the nerve and the vessels. It is related to the weakness of the muscular aponeurotic structures of the pelvis, old ages, constipation, COPD. First case: female 90 years old, clinical occlusion and abdominal cavity blocked by feces and gas with extended abdomen, meteoric. Radiography abdomen shows dilatation of the intestine ansa and levels of idroaerei. Median laparotomy shows intestine ansa reducible in cavity, intestinal resection, direct plastic foramen and plugh femoral incision. Enteric fistula in p.o. treated by medical therapy, healing in 35 days. Second case: female 81 years old, clinical occlusion of intestine with extension and levels seen in abdomen radiography. Median laparotomy shows lateral forcipressure of the ansa in the obturator foramen, liberation and plastic of the foramen with prole-plugh. Discharge from hospital in 9 days. Third case: female 82 years old with reducible inguinal hernia, with intestinal occlusion. Median laparotomy, dilated ansa caused by strangulating of the obturator foramen,

liberation and resection of the ansa, reduction of the inguinal hernia and plastic with double plugh, death in 7 days for IMA. It occurs always with clinical occlusion without specificity, in 50% we can see the sign of Howship-Romberg, compression of the hernia on the anterior branch of the nerve, with flection in extrarotation in the lower limb. The diagnosis is intra-operation. It's useful a TC without contrast medium. Surgical access is not easy for the location in the upper inside face of the thigh underneath the pettineo. The reduction is difficult via abdomen, because there is not enough light on the sac and so the ischemic ansa may lacerate easily, via inferior gives a good access to the sac but not to the collar and the eventual resection is impossible. The hernia plastic obliges the use of prosthesis, otherwise there is a relapse of 25%. According to us in emergency situations without sure diagnosis, the access is laparotomic with an eventual femoral aperture.

Spighelian hernia: a case report

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It's a ventral hernia and can be seen at the point between the spinoumbilical line and the external margin of the anterior rect muscle of the abdomen and the bispinoiliaca line. The anterior wall of the abdomen is constituted by a muscoleaponevrotic barrier formed by trasverse muscles, small and big oblique. An hernia is created when there is a certain continuous solution of the trasverse muscle. There is a particular condition in which there is predisposition for the formation of an hernia in the presence of two weak areas: 1) the union of the muscular fibres of the trasverse with the aponevrosis, which originates from the 9th costal cartilage to the pubic tubercule, the semilunaris line to the medial concavity of Spighel, which represents the border line between the fleshy portion of the trasverse and its aponevrosis. 2) the union line of the trasverse with the abdomen rect. In this tract there are natural orifices for the passage of the lateral perforating rami of the last vessels and the intercostal nervi and the rami of the epigastric inferior vessels. Through these orifices there are the preperitoneal adipe which forms the

head of the ram for the formation of the hernia of Spigel. Clinical case: An obese woman of 56 years; she is recovered for the right parietal swelling. There is swelling of the wall not reducible above the internal inguinal orifice and below the line of Monro, about 6 cm from the iliac spine anterosuperior. Right transverse laparotomy, the oblique external part is opened to the separation of the aponeurosis in the anterior part of the rect, a small orifice through which there is swelling constituted by a big lipoma prehernia and a small sac which, when opened, contains epiploon. Treatment of the sac and closure with a net of prolene. It's a rare hernia, 1% of the hernias of the abdominal wall, in persons who are old females, multipregnancies, obese, COPD, ascitis, trocar. Normally it remains confined under the aponeurosis of the big oblique. It gives uncertain symptoms, with pangs, similar to colics, dyspeptic situations, nausea, vomit. Often the diagnosis is urgent due to strangulation, above all in the small ones, intraparietal, posing diagnosis doubts for fibroma, lipoma, hematoma, external granuloma pieces. An ultrasound scan and TC are useful which give a clear image of the parietal defect and of the content of the hernia. For the reparation of the parietal defect it's always useful to put the prolene net to avoid in this way any risks of relapses.

The extended resections in the treatment of colo-rectal cancer in the elderly

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The extended resection in the treatment of colo-rectal cancer adherent to contiguous organs (cT4) is often considered not advisable in the aged patients. In these patients the surgical risk does not seem proportionate to the immediate and long-term results. The aim of the study is to evaluate the extended surgery for colo-rectal cancer in the elderly. *Patients and Methods:* 469 patients over 75-years old underwent surgical treatment for colo-rectal cancer. 67 of them had a cancer adherent to the near anatomic structures (cT4). The histological reports showed the neoplastic spread

beyond the intestinal wall into the surrounding organs (pT4) in 52 cases (77.6%). The in hospital mortality and morbidity, the 5-years survival and the recurrences' rate are analyzed in the cT4 cases and compared with the results obtained in the other patients who underwent standard surgical treatment. *Results:* The mortality was 11% after standard surgery and 9% after extended surgery ($p=0.5991$) and the morbidity 34% vs. 23.9% ($p=0.0996$). As regard as the ASA class, there was no difference in the mortality and morbidity between the two groups (ASA1 $p=0.565$; ASA2 $p=0.3079$; ASA3 $p=0.2599$). The cause-specific 5-years survival after curative surgery in the two groups was 72.95% and 49.9% respectively. The survival in the Dukes A-B patients was 80.2% after standard resections and 70.1% after extended resections ($p=0.1120$); in the Dukes C patients the survival was 55.1% vs. 16.2% ($p=0.0002$) respectively. At the multivariate analysis (Cox regression model) the cT4 is an independent prognostic factor ($p=0.0004$; ExpB=3.375). *Conclusion:* The extended resections are indicated in the aged affected by cT4 colorectal cancer, when feasible in selected patients. The advantages are: good long-term results if the resection is curative and the tumour is pN0; a quality of life after palliative resection better than after other palliative treatments.

Treatment of umbilical hernia in local anesthesia

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Objectives: Umbilical hernias are a common surgical problem with a high recurrence rate using conventional suture techniques. The aim of our study is to prove that the mesh technique in the treatment of umbilical hernia in local anesthesia could improve results for the correction of the umbilical defects allowing low recurrence rate, with immediate rehabilitation and few complications. *Material and methods:* In our division from October 1998 to November 2004 we have performed 48 operations for acquired umbilical hernia, 32 males and 16 females with a median age of 51 years (range 20 to 86 years). In 37 pa-

tients (77%) the diameter of parietal defect was less than 6 cm. The anaesthetic technique of choice was local anaesthetic infiltration in 42 (87.5%) patients and a light intravenous sedation added in six particularly anxious patients. Through a semilunar under umbilical skin incision the margins of the sac were freed from the edges of the defect and a space was made in the pre-peritoneal space to accommodate a little sample of polypropylene net which exceeds almost of two centimetres the edge of hernial defect. A 24 hours aspiration drainage has been utilized in 13 (27%) cases. *Results:* Follow-up has a 30 months period of observation and at the moment recurrences are not reported. Among the complications only 1 (2%) seroma which required needle aspiration postoperative pain was mild and required hospital analgesia in only 9 (18.75%) of cases and domiciliary analgesia in 15 (31.2%), but that has not prevented a precocious and correct deambulation. No patient had severe postoperative pain. Dehospitalization has taken place within 48 hours. *Conclusions:* The matured experience with the use of prosthesis in the hernial surgery has persuaded us to extend the indications also to the treatment of umbilical hernia and the use of prosthetic nets becomes a fundamental therapeutic stage and perhaps an important answer to a request of health service which are always more demanding in terms of: security, relapse and rapid recovery with a minimum pain.

Classification and therapeutic protocol of the recurrent groin and crural hernia

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Objective: In the surgical of hernias, recurrences have always represented one of the principal parameters for measuring the effectiveness of one technique in comparison with others. Management of recurrences, whether single or multiple, is difficult, both technically and because of its psychological repercussions for the patient. The Authors report a personal and original classification of the inguinal and crural recurrent hernia, granting to the surgeon a correct frame of this pathology, addressing him to the choice of the most

suitable surgical and anaesthesiological technique. *Materials and methods:* From January 2000 to January 2005, in the General Surgery Institute of the University of Naples "Federico II", 1150 hernioplasties have been performed, in 1084 patients; in 230 cases we faced recurrent herniae. Examining our casuistics as to the recurrences, 180 cases were inguinal herniae and 50 cases were crural herniae. For the surgical treatment of recurrent herniae, in 23 cases we preferred an anterior approach according the Lichtenstein's technique, in 140 cases we preferred a preperitoneal approach according the Trabucco's technique, in 67 cases we preferred the Stoppa's technique. *Results:* From our clinical experience, we pointed out how the laparotomic treatment of the recurrent herniae must be personalized on each patient, considering all those aspects which make each hernia different one from another. We think, infact, the choice of the surgical technique must consider a wider clinical evaluation basing on 5 parameters: the kind of the hernial defect, the dimensions of the hernial defect, the plurirecurrence; the reducibility; the somatic characteristic of patient. So, we have create a recurrent herniae classification; type 1 (first inguinal recurrent hernia, "obliquus external, reducible, small dimension <2 cm in no fat patients); type 2 (first inguinal recurrent hernia, "direct", reducible small dimension <2 cm in no fat patients); type 3 (all the other cases). *Conclusions:* Following such classification, we thought to proceed on the grounds of the following schema: facing a type 1 recurrent hernia, we use an anterior approach according to Lichtenstein; facing a type 2 recurrent hernia, we prefer a preperitoneal approach according to Trabucco; facing a type 3 recurrent hernia, we prefer the Stoppa's technique or, alternatively, the laparoscopic one.

Age based case control study of Longo mucoprolapsectomy

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Objective: Making a comparison, into our 120 patients database, between patients 65 years older (Case)

and younger (control) undergone an haemorrhoidectomy with stapler. *Materials and methods:* Between May 2001 and December 2004 120 patients, of whom 22.5% of 65 years older (bound included), underwent haemorrhoidectomy with stapler. Briefly description follows: 1st group; 51.85% of males and 48.15% of females; ASA scale evaluation results 63% ASA II and 37% ASA I; 3.7% cases of II degree haemorrhoids with prolapse, 51.85% of III e 44.45% of IV; 3.7% underwent general anesthesia, 7.4% sacral one 4.8% subarachnoides one plus sedative, 74.1% subarachnoides one. 2nd group 65 years younger; 61.3% of males and 38.7% of female; 2.14% ASA III, 17.2% ASA II and 80.66% ASA I; 9.2% cases of II degree haemorrhoids with prolapse, 64.4% of III and 26.4% of IV; 6.42% underwent general anesthesia, 1.07% sacral one, 35.31% subarachnoides one plus sedative, 57.2% subarachnoides one. *Results:* In 96% of the cases the procedure was one-day surgery with 1.11 hospitalisation days for 1st group while 1.15 days for 2nd; operation average time 28.7' and 29.33' in 1st group e 2nd respectively; 2.84 hemostasis stitches for 1st group, 3 for 2nd. Immediate complication was post operative bleeding, needed surgical hemostasis or blood transfusion, observed in 9 cases of whom 2 in 1st group and 7 in 2nd. Post operative delayed complications were: 1 cases of ragade bleeding, 1 cases of stenosis anal canal and 1 case of persistent anal pain, discovered at all into 2nd group. 1st group patients average satisfaction 9.55, while 2nd 8.9. *Discussion:* In 1st group presentation symptoms were 51.85% bleeding, 18.51% pain, 3.7% itch; in 2nd group were 58.06% bleeding, 44.08% pain, 1.07% itch. Post-operative symptoms in 1st group were 7.4% incontinence, 7.4% tenesmus, 7.4% sense of incomplete evacuation while in 2nd group were 4.3% discomfort, 2.15% constipation, 3.22% soiling and 1.07% tenesmus. You can say haemorrhoidal disease has different presentation and post-operative symptoms between two groups. Seems to be no difference between surgical procedure about performance time $P=0.78$ and hemostasis stitches $P=0.36$. Also patients post-operative judgement has no significant difference $P=0.33$. *Conclusions:* Authors conclude that Longo technique for the surgical treatment of haemorrhoids with prolapse, has a defined and specific place, applies to older patients with same indication of younger.

Case report: multifocal cancer

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We report the case of a patient (male, 66 years old) that we observed, who referred a 4 month story of nausea and vomiting linked with weight loss and emo-occult test positivity. The case history also referred miastenia gravis and diabetes. The first tests he made (EGDS and colonoscopy) were all negative; he also made a neck ecography wich showed a hypoechogenic lesion in the right lobe of thyroid in addition with multiple nodular formation in the left lobe tending to down into the throat. A small intestine Rx showed a stenosis 1 meter away from the pylorus with dilatation of the previous loop (7 cm). The stenosis is confirmed by TC. A RIA study confirms high levels of Cromogranin A (161.4 ng/ml) and thyreoglobulin (226.6 ng/ml). An Octreoscan showed an accumulation of tracing in the thyroid. For all these reasons we decided to make a total thyreodectomy after which the histology showed a mixed follicular-papillar tumour with diffused presence of Cromogranin. A post operatory RIA pointed out the normalization of the cromogranin and the thyreoglobulin. In a month the patient underwent the intestinal stenosis resection with histological diagnosis of a middle differentiated adenocarcinoma with node metastasis. For this reason he made an adiuvant chemotherapy and several check tests in the months to come up to 3 months ago, which didn't show a reactivation of the cancer. Two months ago he had a kidney colic and a RX showed several calcium stones in the pelvic area on both sides. Lately he has also had acute episodes of urine retention; he underwent a kidney scintigraphy which showed a poor perfusion of the right kidney and pelvis enlargement and a pelvic TC which gave sign of a prostatic lesion. This supposed tumour also included the bladder and the right ureter. *Conclusions:* This case shows the utility of measuring cromogranin, which has a sensibility between 80% and 100% in the neuroendocrine cancers, and of Octreoscan which is to-

day the best mean of scintigrafic investigation, although in our patient the histology confirmed a mixed follicular-papillar cancer instead of a neuroendocrine tumour. For all these reasons it could be a valid idea to use those means of investigation also in

non neuroendocrine tumours. The second point that comes out from this case is the high aggressiveness of the prostatic lesion which involved both the bladder and the ureter in only 2 months' time.