

**Case description:** An 83-year-old lady presented to the surgical out-patient clinic with upper abdominal pain radiating to left side of her chest. She had recent history of significant weight loss, approximately 22kg. Abdominal examination was unremarkable.

**Results and Conclusions:** Haemoglobin and Liver Function Tests were normal. Gastroscopy showed one large 3cm ulcer with a shaggy base and rolled over margin in the first part of the duodenum (D1) which appeared malignant. Initial histology confirmed adenocarcinoma of uncertain origin. CT scan showed a 2.9x3.7cm partially cystic mass lesion in the head of the pancreas that was locally invading into the first part of the duodenum, with no evidence of metastases. Immunohistochemistry showed strong Ca19.9 positive, favouring primary pancreatic origin.

**Take home message:** Pancreatic cancer presenting as an ulcer in D1 is very rare. If a suspicious looking ulcer is found endoscopically at D1, it should be biopsied. A CT scan of the abdomen is also important in the work-up of such cases.

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## Changing standards in the treatment of desmoid tumors?

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**Objectives:** Desmoid Tumors (DT) are rare locally aggressive and never metastasizing mesenchymal tumors. They usually grow slowly and often present on the trunk or extremity, on the abdominal wall or intra-abdominally. Radical surgical removal has been considered the treatment of choice for many years, although high recurrence rates ranging from 30% to 40% have been reported.

**Methods:** A 40-year old woman was referred to our department with a 4cmx2cmx3cm painless hard tumor on the lateral wall of the right thorax. A histological diagnosis of a DT was made after a biopsy specimen was obtained. After initial R0 surgical resection the patient developed a chronic pain syndrome. Another surgical R0 resection was performed after local recurrence was noted in an MRI fifteen months postoperative. 30 months after the first operation and 17 months after the second operation a second local recurrence was seen. A third operation was planned but the patient chose not to undergo surgery and was referred to the medical oncologist. A therapy with tamoxifen was started and supplemented with sulindac after two months since a tumor progression was shown in the first follow up MRI.

**Results:** The follow up under the tamoxifen/sulindac therapy showed disease stabilization after 12 months and a complete tumor regression after 1½ years. The tamoxifen/sulindac regimen and the follow-up were continued, and the patient is now tumor free after 3½ years of medical treatment. The pain syndrome has also improved although the patient is still under oxycodone therapy.

**Conclusions:** In current practice, the treatment of desmoid tumor medical therapy was reserved to unresectable disease or where radical resection would have brought to major functional or cosmetic losses. This present case calls into question the established surgical therapy of desmoid tumors. Although a strong evidence-based treatment is still missing, other recent studies have also suggested alternative different therapeutic strategies based on a “wait and see” strategy may be effective in the case of asymptomatic disease.

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## A case report of metastatic renal oncocytoma

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**Introduction:** Renal oncocytomas are renal tumours that are largely considered to be benign. They represent 5.5% of all renal tumours and the age-standardised incidence is 0.3 per 100,000/year in men and women.<sup>1</sup> Despite this, there have been reported cases where these tumours have developed metastases. We report the case of a patient who had a right radical nephrectomy for renal oncocytoma who then presents nine years later with a pathological neck of femur (NOF) fracture secondary to metastases, suggesting malignant behaviour of the tumour.

**Case description:** A 62-year-old lady presented in December 2010 with shortness of breath on exertion, frontal headache and malignant hypertension. She was treated with Ramipril and her blood pressure subsided. On discharge she underwent further investigations, including 24hour urine catecholamine test – (normal), and abdominal ultrasound which revealed a mass in the right kidney. Computerized tomography (CT) confirmed a well-defined lower pole right renal solid mass measuring 7.5x5.7cm, extending to the renal pelvis with compression of the vascular pedicle. There was no evidence of extrarenal extension. Renal cell carcinoma stage T2 was suggested. She underwent a right laparoscopic nephrectomy and recovered well from the operation. Histology confirmed oncocytoma with atypical features of extrarenal invasion, absence of Hale's colloidal blue staining, negativity for cytokeratin 7 and positive vimentin staining. This patient had yearly follow-up CT. Four years after her first surgery, a nodule was noted in the right nephrectomy bed. Surgical excision confirmed recurrent oncocytoma. Two years after this she presented with pathological fracture of her right neck of femur. A bone biopsy confirmed metastatic disease. She had a dynamic hip screw fixation.

**Results and Conclusions:** The World Health Organization classifies renal oncocytoma as benign neoplasm.<sup>2</sup> Nevertheless there are case reports of metastatic disease in these tumours. Studies have revealed a classical pattern with typical features of benign neoplasia in 57.5–67% of cases. Malignant features such as atypical histological pattern, focal necrosis, multinucleation, mitotic activity, degenerative atypia and invasion of extrarenal fat have been described in others. Despite this, not all patients with such features progress to developing metastatic disease at 5-year follow-up. In fact only 2 patients out of 42 with atypical features developed metastatic disease.<sup>3</sup> This suggests that there is a potential for metastatic transformation of this tumour, especially in the group with features of atypia. There is a however, paucity of information in published literature regarding this. The risk stratification of these atypical features will be a good start. Clearly, further research by way of genetic assessment, including chromosomal and tumour markers is required, as part of future diagnosis and management algorithm.

**Take home message:** Metastatic renal oncocytomas are extremely rare. Little is known about the atypical features that predispose metastatic transformation. Our patient developed local recurrence and a distant metastatic lesion with fracture neck of femur 6 years later. Our extensive search of literature has shown only 2 other reported cases of metastatic oncocytomas in the bone being the tibia and femur. The patient with the femoral fracture had multiple bone metastatic lesions. Further research into the biological features and characteristics of this extremely rare condition is required. This may help stratifying patients into metastatic risk potentials. Perhaps treatment plans can be tailored accordingly.

## References

- 1) Gudbjartsson T, Hardarson S, Petursdottir V, Thoroddsen A, Magnusson J, Einarsson GV, Renal oncocytoma: a clinicopathological analysis of 45 consecutive cases. *BJU Int.* 2005 Dec;96(9):1275-9.

2) World Health Organization classification of tumours. Pathology and genetics of tumours of the urinary system and male genital organs, IARC, 2004.

3) Perez-Ordóñez B, Hamed G, Campbell S, Erlandson RA, Russo P, Gaudin PB, Reuter VE, Renal Oncocytoma: A Clinicopathologic Study of 70 Cases, *American Journal of Surgical Pathology*. 1997 Aug;21(8):871-83.

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## Emergency laparotomy with synchronous Caesarean section for life-threatening strangulated Petersen's hernia

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**Introduction:** Bariatric surgery is the most effective treatment for morbid obesity and its co-morbidities. Women are advised against becoming pregnant in the first 12-18 months after surgery due to the potential nutritional compromise induced by weight loss. An increasingly recognised complication following bariatric surgery are Petersen-type internal hernias. We present a case of life-threatening Petersen's hernia at 31 weeks of pregnancy in a patient who had previously undergone laparoscopic Roux-en-Y gastric bypass for morbid obesity.

**Case description:** A 31-week pregnant 28-year-old (G2P1) presented as an emergency with abdominal pain, vomiting and absolute constipation. Two years previously she had undergone a laparoscopic Roux-en-Y gastric bypass and had lost 31kg. She was tachycardic, tachypnoeic and pyrexial. Blood tests performed showed a raised white cell count  $14.4 \times 10^9/L$ , haemoglobin 114g/L, C-reactive protein 36mg/L, urea 4.1mmol/L, creatinine 64 $\mu$ mol/L and lactate 1.94mmol/L.

An abdominal ultrasound scan showed free fluid in the abdomen and confirmed a viable intra-uterine foetus. A targeted abdominal computer tomographic (CT) scan showed a closed loop obstruction of the jejunum and proximal ileum around the Roux-en-Y reconstruction, most likely an internal hernia of Petersen. The herniated small bowel was non-enhancing, distended and fluid-filled, therefore thought to be non-viable radiologically.

**Results and Conclusions:** The patient underwent emergency Caesarean section followed by laparotomy, small bowel resection and formation of laparotomy. She was returned to theatre 24 hours later for a second-look laparotomy. The intra-operative findings demonstrated healthy common channel measuring 270cm, bilio-pancreatic limb measuring 80cm and a long narrow gastric pouch and a small alimentary limb remnant. The gastric bypass was reversed by excising the remnant alimentary limb and fashioning gastro-gastrostomy and anastomosing the bilio-pancreatic limb to the common channel. The patient made an uneventful recovery. Clinicians involved in the management of patients with previous gastric bypass should be aware of the potential complications. We suggest that obstetric care of post-operative bariatric patients requires early liaison with the bariatric surgical team.

**Take home message:** Obstetric care of post-operative bariatric patients requires early liaison with the bariatric team. Clinical presentations of Petersen's hernia are non-specific and clinicians should have a high index of suspicion of this diagnosis when assessing patients with previous surgery involving Roux-en-Y reconstruction.

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## A case of choledocholithiasis secondary to post cholecystectomy clip migration

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**Introduction:** The commonly reported risks of a cholecystectomy include bile leak, bile duct injury, infection, bleeding, and retained gallstones. Approximately 1-2% of all patients who undergo cholecystectomy have stones left in the common bile duct (CBD) that require further intervention. The use of surgical clips to ligate the cystic duct has been routine since the advent of the laparoscopic cholecystectomy as the standard of care in the 1990s. One rare risk associated with the use of surgical clips is a migrated clip that can result in an obstructed CBD.

**Case description:** The patient is a 72 year old male who presented with sudden onset, severe, right upper quadrant (RUQ) pain with associated nausea and vomiting after eating fried food. His past surgical history was significant for an uncomplicated laparoscopic cholecystectomy 7 years prior for acute cholecystitis. The patient had been having intermittent RUQ pain for 2 years prior to his presentation and had undergone an esophagogastroduodenoscopy that demonstrated mild gastritis. The patient had no other surgical or procedural history.

On examination, the patient had mild tenderness to palpation in the RUQ. Of note, his labs were significant for a white blood cell count of 11000, aspartate aminotransferase of 760, alanine aminotransferase of 427 and total bilirubin of 3.0. A computed tomography scan demonstrated a hypodense lesion in the intrapancreatic common bile duct with the morphology of a surgical clip measuring 7mm. Magnetic resonance cholangio-pancreatography confirmed the CT findings. The decision was made to proceed with an endoscopic retrograde cholangio-pancreatography (ERCP) from which a clip inside a sludge ball was extracted. The patient tolerated the procedure well and underwent a routine post-procedure course.

**Results and Conclusions:** Post cholecystectomy clip migration is a rare condition that can lead to choledocholithiasis and cholangitis. Pre-disposing factors that have been suggested include cholecystitis, post-operative complications and the use of an excessive amount of clips. It has been theorized that the mechanism for clip migration is secondary to inadvertent placement of clips in the biliary tree, clip slippage or sub-clinical bile duct injuries. The appropriate treatment strategy for choledocholithiasis secondary to post cholecystectomy clip migration is ERCP.

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## Disappearance of a spontaneous intrahepatic porto-systemic shunt managed by hepatic vein closure: Why?

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**Introduction:** Spontaneous intrahepatic portosystemic shunt (PSS) is uncommon. A few cases have been reported with its disappearance after outflow occlusion. It is unclear why it had disappeared, and the mechanism is closely related to the pathophysiology of PSS. The portal