

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