

## **ROBOTIC EXTENDED LEFT HEPATECTOMY AND ROUX-EN-Y HEPATICOJEJUNOSTOMY FOR PRIMARY INTRAPANCREATIC LITHIASIS**

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### **Introduction:**

Hilar cholangiocarcinoma is the most common malignant neoplasm of the biliary tract. Surgical resection is the only curative modality of treatment. The aim of this video is to present a robotic left hepatectomy extended to caudate lobe, combined with lymphadenectomy, and Roux-en-Y hepaticojejunostomy.

### **Material and Method:**

A 74-year-old man presented with jaundice. MRI showed a 4.6 cm tumor involving the hepatic hilum. The tumor was deemed inoperable and neoadjuvant treatment with durvalumab plus gemcitabine and cisplatin was initiated. After 6 cycles of treatment, the tumor had shrunk, and the multidisciplinary team opted for surgical treatment. A robotic approach was proposed and consent was obtained.

### **Results:**

The total operating time was 320 minutes. The estimated blood loss was 140 mL and no transfusion was required during or after surgery. Recovery was uneventful and the patient was discharged on postoperative day 5. No bile leakage was observed. Pathology confirmed a 4.2 x 3.0 cm cholangiocarcinoma with free surgical margins (T2N1).

### **Conclusion:**

Robotic left hemihepatectomy with Roux-en-Y hepaticojejunostomy is safe and feasible. This complex procedure should be performed by experienced surgeons in both open and robotic surgery.

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## **MINOR HEPATOPANCREATICODUODENECTOMY FOR PANCREATIC NET WITH GALL BLADDER MASS**

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### **Introduction:**

Hepato-pancreatico-duodenectomy (HPD) is performed usually in patients with carcinoma Gall bladder involving the pancreatico-duodenal groove or when there is suspicion of a dual malignancy in periampullary region and gall bladder.

### **Material and Method:**

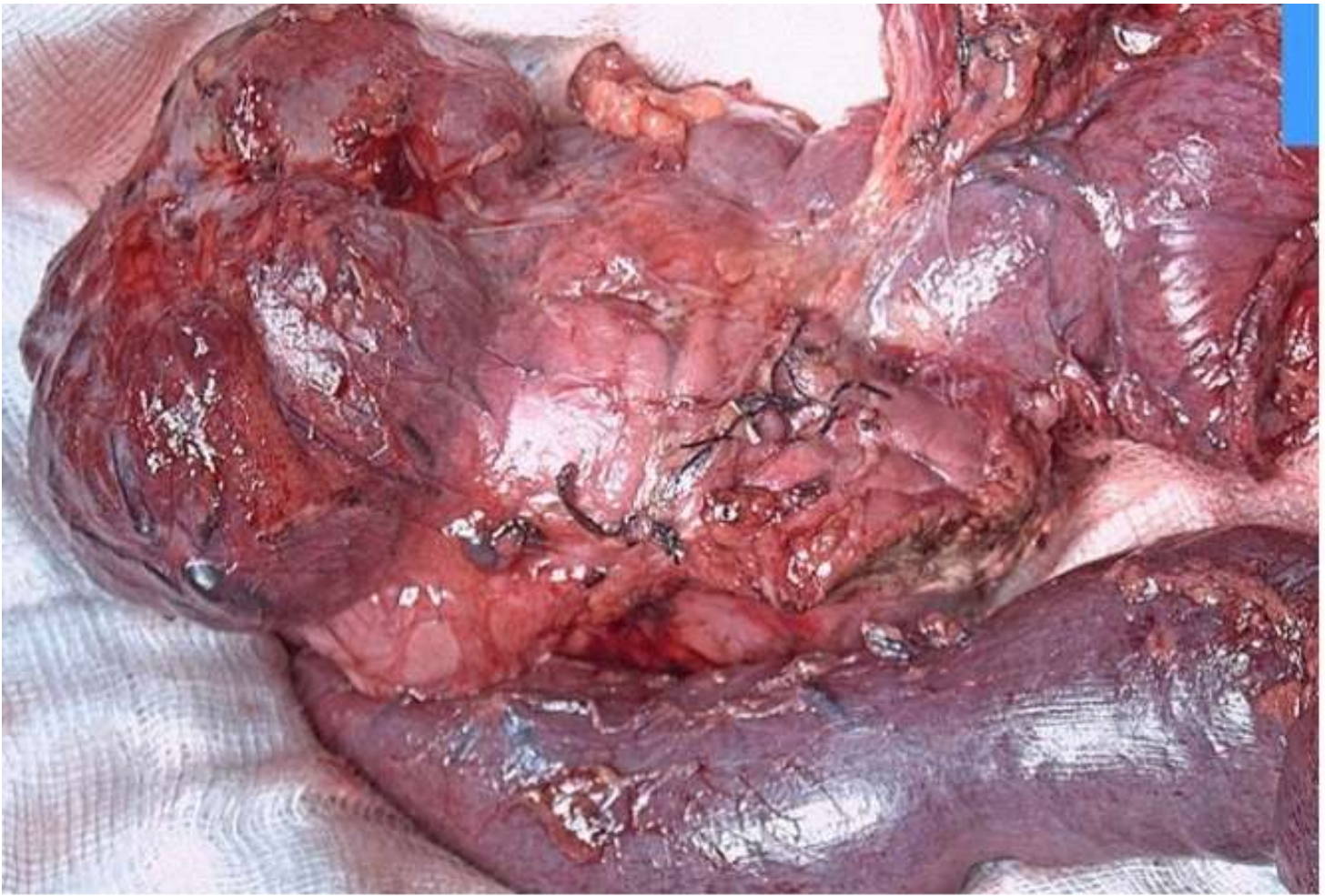
55-year-old male with h/o Pain right hypochondrium, vomiting & weight loss found to have a cystic lesion near 2nd part duodenum during evaluation. CT scan showed 7x5 cm lesion in head of pancreas and irregular mural thickening in fundus and body of gall bladder. EUS reported 6x5 cm cystic mass Uncinate process of pancreas. FNA Biopsy was Well Differentiated NET Grade 1, Ki-67 – 1%. DOTANOC scan had SSTR expressing lesion in duodenum with loss of planes with pancreas with thickening in fundus and body of Gallbladder

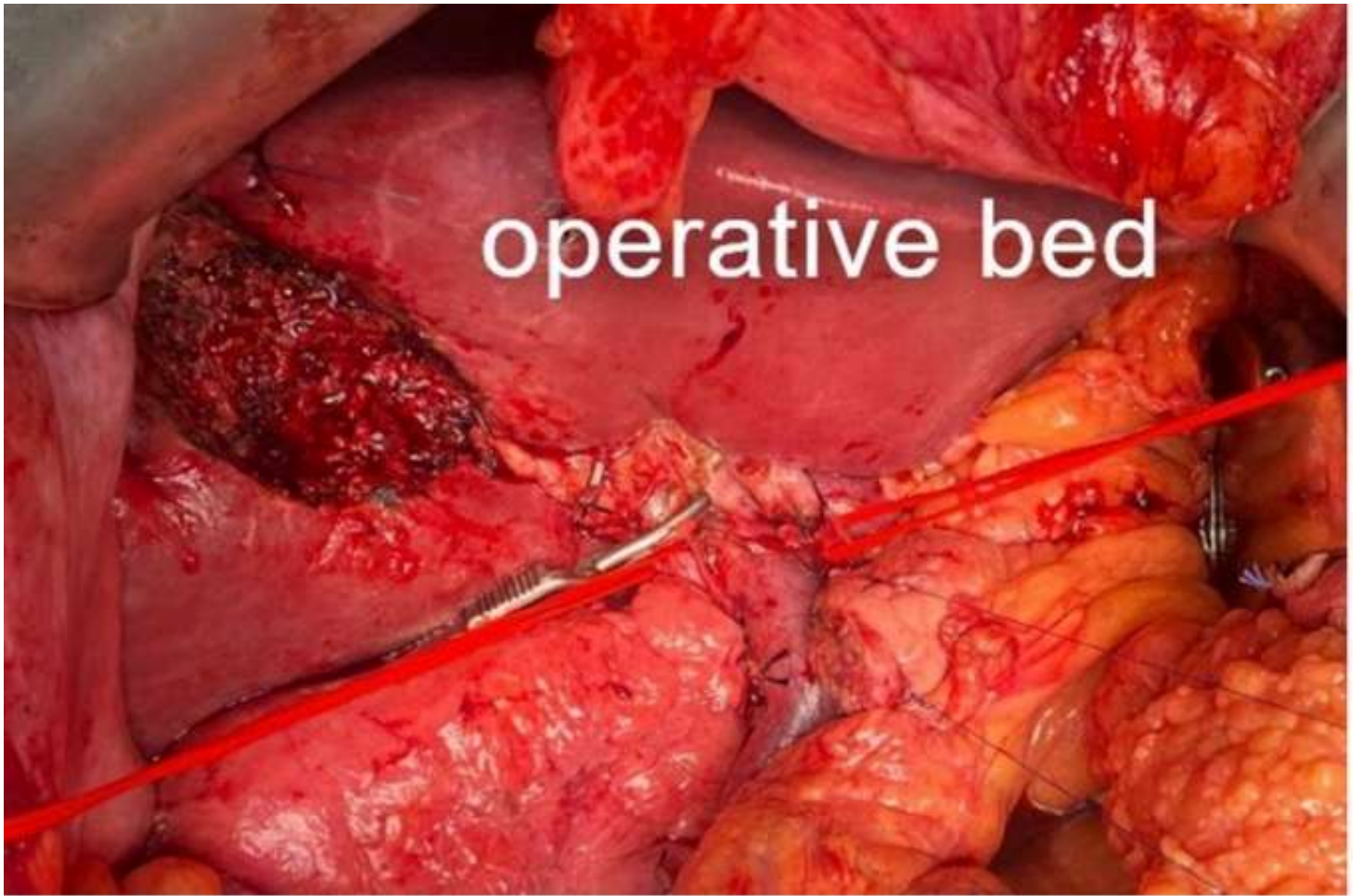
### **Results:**

Minor Hepatopancreaticoduodenectomy (HPD) with FJ was performed. 6x5 cm tumor in head & uncinata process of pancreas. Mesocolon infiltration + Thickening in fundus and body of gallbladder. PD – 2mm. CHD – 5 mm. No Pringle's manoeuvre. Pancreatico-jejunal anastomosis by invagination. Hepatico-jejunostomy done with interrupted PDS 5-0. Duration of Surgery -12 hours. Blood loss:500 ml. No intra-op blood transfusion. Post-operative Course: Orals started on POD3. Grade B POPF which required drainage. Discharged on POD 21

### **Conclusion:**

A Minor Hepatoma-pancreatico-duodenectomy can be safely performed in patients with suspicion of dual malignancy involving periampullary region and gallbladder (pancreatic NET with ?Ca GB in this case) with excellent results.





operative bed

## LARGE RETROPERITONEAL CYST CAUSING EXTRINSIC COMPRESSION OF THE COLON AND CHRONIC CONSTIPATION

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### **Introduction:**

Chronic constipation has an estimated prevalence of 15%. Current guidelines focus on motility disorders and do not recommend routine imaging in the absence of alarm signs. However, extrinsic compression of the colon is a rare but important cause that may be missed without imaging.

### **Material and Method:**

A 60-year-old female with history of left donor nephrectomy, hypothyroidism, dyslipidemia, and hyperuricemia presented with abdominal pain initially attributed to gallstones. She reported longstanding constipation (4–5 days between bowel movements), nausea, bloating, and a palpable right lower quadrant mass. FOBT was positive. Colonoscopy showed extrinsic compression of the right colon. CT and MRI demonstrated a large retroperitoneal cystic lesion displacing the colon, suggestive of an inclusion or duplication cyst. Laparoscopic resection was performed with lateral-to-medial dissection, achieving complete removal. The cyst was unrelated to the mesentery or right kidney.

### **Results:**

Postoperative recovery was uneventful. Cultures and BAAR were negative. Pathology confirmed a simple retroperitoneal cyst with no evidence of malignancy. The patient is currently asymptomatic with daily bowel movements.

### **Conclusion:**

This case highlights the importance of considering secondary causes of constipation in patients refractory to medical therapy. Delayed diagnosis may result in severe complications, lesion growth, or malignant transformation. Retroperitoneal cystic lesions have a broad differential diagnosis and require thorough preoperative evaluation and multidisciplinary management, as demonstrated by gynecology and urology consultations in this case.

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## **DOUBLE GALLBLADER. COMMON DISEASE, NOT SO COMMON PRESENTATION**

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### **Introduction:**

Gallbladder duplication is a rare congenital malformation, with an estimated incidence of 1 in 4,000-5000. Harlaftis' classification divides it into two types: type 1, which is a split primordium with a single cystic duct; and type 2, which involves an accessory gallbladder and multiple cystic ducts. Among type 2, H-type (two gallbladders, each with an independent cystic duct draining into the common bile duct) is the most common. Magnetic resonance cholangiopancreatography (MRCP) is the most sensitive diagnostic method.

### **Material and Method:**

A 37-year-old woman presented to the emergency room with right upper quadrant abdominal pain radiating to the ipsilateral shoulder. She reported nausea, had tenderness on palpation and a positive Murphy's sign. Laboratory tests showed mild leukocytosis with other values within normal limits. Abdominal ultrasound revealed a double gallbladder with signs of acute cholecystitis. MRCP confirmed H-type duplication. Laparoscopic cholecystectomy was indicated.

### **Results:**

Indocyanine green was administered preoperatively. During Calot's triangle dissection, two cystic ducts and one cystic artery were identified. Indocyanine green confirmed the anatomy. A cholangiography was performed on both cystic ducts confirming independent drainage into the common bile duct. Clips were placed on both cystic ducts and the artery followed by their transection. Both gallbladders were successfully dissected from the liver and extracted without complications.

### **Conclusion:**

Duplicated gallbladder is an uncommon anatomical variant. Assertive preoperative identification allows a proper surgical planning and safe approach. Complete resection of both gallbladders prevents recurrence or future complications. While laparoscopic cholecystectomy is effective, conversion to open surgery may be necessary in some cases.

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