

AS14-4

Management of huge defects following extensive abdominal wall neoplasm resection: classification and immediate reconstruction

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Objective: We report our experience in extensive resection and immediate reconstruction in treatment of patients with abdominal wall neoplasms based on a simple and practical classification of abdominal wall defects.

Methods: Between January 1999 to December 2015, 112 patients with abdominal wall neoplasms were treated with extensive resection which included a >3 cm tumor-free margin, this led to a huge abdominal wall defect, the mean size of defects was 211.58 ± 89.3 cm². All patients were performed immediate abdominal wall reconstruction including primary sutures or free skin graft for Type I defects, component separation (CST) with or without mesh reinforcement for Type II defects and pedicled or vascularized myocutaneous flap with or without mesh or prosthetic + biological mesh with or without CST for Type III defects.

Results: The average follow up was 76.86 ± 21.22 months, There was no severe morbidity after the operation. 3 patients developed flap necrosis, other major wound complications were identified in 9 patients and local neoplasm recurrence was observed in 20 patients including 12 primary neoplasm and 8 secondary neoplasm patients. 25 patients developed distant metastasis including 10 primary neoplasm and 15 secondary neoplasm patients. There was 4 patients developed hernia.

Conclusions: Strategy based on the abdominal wall defect classification system for immediate reconstruction of huge abdominal wall defects seems to be safe and effective in treatment of patients with abdominal wall neoplasms.

AS14-5

Abdominal wall reconstruction using human dermis biologic mesh after resection of recurrent fibrosarcoma of the rectus muscles

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The Fibrosarcoma is a tumor composed of malignant fibroblasts in a collagen background. In general terms it occurs as a primary or secondary bone tumor but more rarely as a soft-tissue mass. It is a locally invasive neoplasm with a high recurrence rate. The treatment of fibrosarcomas involves a combination of adequate surgical resection with a cuff of normal tissue and Adjunctive therapy, to improve local control. In case of large soft tissue tumors the challenging reconstruction of the subsequent defect is one important step in the management. The authors report a case of 31 years old gentleman with a history of resected fibrosarcoma in the left rectus muscle, who presented 2 years later with painless mass in the anterior abdominal wall. After investigation with ultrasound, CT scan and MRI it was diagnosed as 7 cm recurrence in the right rectus muscle.

The patient had "en bloc" excision of the tumor (taking the full thickness of the abdominal wall from the skin till the peritonea) with 3 cm safety margin around the tumor. Keeping a defect of about 20x15 cm. the abdominal wall reconstruction was done by human dermis biologic mesh used as substitute flap. After component separation a second light weight mesh was placed between the large muscles.

The postoperative was uneventful. Histologic findings were consistent with the diagnosis of fibrosarcoma and the patient had adjunctive radiotherapy. After one year of follow up the patient is in remission.

AS15-1

The Essentials of Writing a Surgical Manuscript

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The different types of surgical manuscript possible for publication include Letter to the editor, Case report, Surgical technique (How I do it), Cohort study, Case control study, Randomised controlled trial, Review article and Editorial. A formal consent of a proposed study protocol first needs to be obtained from the local Institutional ethics committee. All clinical trials need to be registered. The basic structure for writing a surgical manuscript consists of the IMRAD structure which stands for Introduction, Methods, Results and Discussion. The Introduction comprises a brief lesson on the proposed subject available in literature and the problem that was addressed in the study. The method section comprises the story of what the authors did and this should be arranged in a logical framework of time. The Results section is the story of the main findings of the study. In the Discussion section, the first paragraph summarises the methodology and results of the study. Also the discussion segment includes a synopsis of similar studies (and how the present study fits in), strengths and limitations of the study and implications of the current study on future research, future policy and clinical practice. The role of a Biostatistician is important for protocol development, data management, and study implementation and monitoring. The contents of the manuscript need to be short and precise. The language should be clear and words / phrases should be simple. Generally, the shorter the manuscript the better.

AS15-2

How to improve the chances for getting your paper published in Hernia

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AS15-3

Electronic publishing in biomedical journals

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Journals in printed format have been the traditional mode of dissemination of scientific knowledge. The disadvantages of the print journals include a) time consuming peer review process, b) lag between submission and publication, c) distribution limited to paid subscribers and d) problems associated with archiving and storage of the journals. With the explosion in the computer technology and worldwide web, electronic publishing of biomedical journals has become the norm over the past several decades. This online and web based publishing is either standalone or complements the print version of the journal. This presentation examines and highlights the pros and cons of electronic publishing of biomedical journals.

AS16-1

Laparoscopic Approaches for Parastomal Hernia Repair of Permanent Colostomy: A Seven-year Follow-up with Low Chronic Pain and Recurrence Rate

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Aim: To assess the treatment and prevention of parastomal hernia using a laparoscopic repair technique.

Methods: From January 2007 and January 2014, we retrospectively reviewed 184 patients who underwent a permanent colostomy. As a routine oncologic follow-up, abdomino-pelvic computed tomography was used to examine the occurrence of the parastomal hernia. The parastomal hernia was repaired by laparoscopic approach using prosthetic material. The associations of age, sex, pain, recurrence, body mass index (BMI), history of steroid use and comorbidities to the development of the PH were analyzed. The 7-year cumulative incidence rates of parastomal hernia were compared according to clinical variables using a Kaplan-Meier analysis.

Results: Our data showed that our postoperative recurrence was very low (3.95%). We found that moderate pain was 12 patients (15.79%), and severe pain was 5 patients (6.58%). During follow-up, 76 patients developed a PH and the 7-year cumulative incidence rate of a parastomal hernia, obtained by using the Kaplan-Meier method. In the multivariate COX analysis, route of stoma creation, BMI, radiation history, and diabetes mellitus were all independent risk factors for the development of a parastomal hernia.

Conclusions: The significant risk factors of a parastomal hernia were as follows: route of stoma creation, BMI, radiation history, and diabetes mellitus. Laparoscopic approach is an effective and simple procedure to correct parastomal hernias with acceptable complication rates and is feasible even in the parastomal hernia patients.