3rd BELGIAN SURGICAL WEEK
Knokke, 2 - 4 May, 2002

Surgical Pitfalls and Complications

PROGRAMME AND ABSTRACTS

Major Sponsor: Johnson & Johnson
The 3rd Belgian Surgical Week is organised together with the:

- Belgian Association for Cardio-Thoracic Surgery (BACTS)
- Belgian Association for Pediatric Surgery (BELAPS)
- Belgian Association of Surgical Trainees (BAST)
- Belgian Group for Endoscopic Surgery (BGES)
- Belgian Society for Surgical Oncology (BSSO)
- Belgian Society for Vascular Surgery (BSVS)
- Belgian Trauma Society (BTS)
- Benelux Association of Bariatric Surgeons (BABS)

and the Sections of the RBSS:

- Belgian Section for Abdominal Wall Surgery (BSAWS)
- Belgian Section for Breast Surgery (BSBS)
- Belgian Section for Colorectal Surgery (BSCRS)
- Belgian Section for Endocrine Surgery (BSES)
- Belgian Section for Hepatobiliary and Pancreatic Surgery (BSHPS)
- Belgian Section for Upper GI Surgery (BSUGIS)
Programme at a Glance

Thursday, May 2nd

08.00  Registration
09.00  BABS Spring Meeting (Magritte Room)
09.30  How I do it (Auditorium)
10.30  Break
11.00  BABS Spring Meeting (Magritte Room)
11.00  How I do it (Auditorium)
12.00  Walking Lunch
12.30  BTS General Assembly (Magritte Room)
13.00  RBSS: Ethical session (Auditorium)
14.00  BAST Surgical Forum (Magritte Room)
16.00  Break
16.30  BSAWS (Auditorium)
       BTS (Magritte Room)

Friday, May 3rd

09.00  BSCRS (Auditorium)
       BSVS + BACTS (Magritte Room)
11.00  Break
11.30  BSCRS (Auditorium)
       BSUGIS (Magritte Room)
12.30  General Assembly BSCRS (Auditorium)
       General Assembly BSUGIS (Magritte Room)
13.00  Walking Lunch
14.00  BSHPS (Auditorium)
       BSBS (Magritte Room)
15.30  Break
16.00  BSHPS (Auditorium)
       BSSO (Magritte Room)
17.30  General Assembly BSHPS (Auditorium)
       General Assembly BSBS (Magritte Room)
18.30  Happy Hour offered by Tyco Healthcare
20.00  Gala Dinner

Saturday, May 4th

09.00  BGES (Auditorium)
       BSVS (Magritte Room)
10.30  Break
10.45  BSES (Auditorium)
       BELAPS (Magritte Room)
12.15  General Assembly RBSS (Auditorium)
Benelux Association of Bariatric Surgeons

Thursday, May 2nd

09.00-12.30 Magritte Room

Moderators: P. Urbain, B. van Ramshorst

09.05: The effects on weight loss after bariatric surgery on plasma concentration of leptin, acute phase proteins and soluble TNF-receptors
Fr. Van Dielen

09.15 Insulin sensitivity does not change in morbidly obese subjects during substantial weight loss after bariatric surgery
J. Wiebolt

09.25 Health behaviours before and after surgery for severe obesity
B. van Ramshorst

09.35 Gastric banding: the Nieuwegein experience
B. van Ramshorst

09.45 Biliopancreatic diversion as a redo operation for failed restrictive gastric surgery
L. Lemmens

Moderators: L. Lemmens, Th. Lafullarde

09.55 First experiences with the laparoscopic gastric bypass for morbid obesity
A. Braakenburg

10.05 Laparoscopic gastric bypass: the IRCAD experience
R. Ceulemans

10.15 Laparoscopic roux-en-y gastric bypass
J. Himpens

10.25 Laparoscopic biliopancreatic diversion
L. Hendrickx

10.40 Break

Moderator: J.W. Greve

11.00 Gastric bypass
Th. Lafullarde

11.30 General Assembly

12.30 Walking Lunch

How I do it

Thursday, May 2nd

09.30-12.00 Auditorium

Moderators: G. Hubens, Antwerpen
B. Hansson, Nijmegen, The Netherlands

09.30 How to have an adequate exposure in laparoscopic colorectal surgery
R. Ceulemans, Strasbourg, France

09.40 How to perform a laparoscopic left colectomy for cancer
A. Kartheuser, Bruxelles

09.50 How to perform a completion angiography after a vascular reconstruction
A. Flamme, Gent

10.00 How I do a Heller Dor myotomy
E. van Vyve, Bruxelles

10.10 How to biopsy/excise a cervical lymph node
E. Fossion, Antwerpen

10.20 How to manage a multiglandular disease in primary HPT
S. Maweja, Liège

10.30 Break

11.00 How to perform an open surgical treatment for Zenker’s diverticulum
T. Lerut, Leuven

11.10 How to close the hiatus during laparoscopic Nissen fundoplication
J. Weerts, Liège

11.20 How to perform a below the knee amputation
C. Randon, Gent

11.30 How to perform a tibial artery revascularisation
H. Van Damme, Liège

11.40 How to perform an open gastro-jejunostomy
P. Mendes da Costa, Bruxelles

11.50 How to perform a safe small bowel resection and anastomosis
O. Detry, Liège

12.00 Walking Lunch

Belgian Trauma Society

Thursday, May 2nd

12.30-13.00 Magritte Room

General Assembly
Royal Belgian Society for Surgery

Thursday, May 2nd
13.00-16.00  Auditorium

Commission for Ethical, Economic and Political Questions

13.00  Patient's rights
   R. Snacken, Ministry of Public Health

Is Malpractice still Allowed for a Physician in 2002?

Moderators:  M.-L. Druart, Bruxelles
             D. Burnion, Bruxelles

13.30  Introduction
   M.-L. Druart, Bruxelles

13.40  Le point de vue de l'expert médico-chirurgical en dommage corporel
   P. Cambier, Bruxelles

14.10  Le point de vue des assurances
   M. Bolland, Liège

14.40  Le point de vue du Conseil de l'Ordre
   J.-P. Squifflet, Bruxelles

15.10  Het standpunt van de jurist
   P. Muylaert, Brussel

15.40  Conclusion
   D. Burnion, Bruxelles

15.50  Discussion

16.00  Break

Belgian Association of Surgical Trainees

Thursday, May 2nd
14.00-16.00  Magritte Room

Surgical Forum

Moderators:  D. Aerden, Brussel
            H. Decaluwé, Leuven

14.00  Prospective evaluation of a collagen matrix substrate in wound healing of severely compromised patients
   J.-P. Brutus, P.G. Harris, Montreal, Canada

14.20  Complications in thrombolysis for lower limb ischemia: an analysis of 100 consecutive cases
   T. Sabbe, F. Vanelst, Sint-Truiden

14.40  Intraperitoneal implantation of a PTFE prosthesis: effect of the side on adhesion formation in an experimental animal model
   R. Chamlou, J.-M. Limbosch, Bruxelles

15.00  Predisposing factors of pharyngocutaneous fistulas complicating head and neck surgery
   D. Dequanter, G. Andry, Bruxelles

15.20  Unusual complication of preperitoneal mesh implantation in the treatment of inguinal hernia
   P. Lauwers, G. Hubens, Antwerpen

15.40  Laparoscopic vertical banded gastroplasty
      Avoiding stapling in continuity: our initial experience in 31 cases
      R. Deleersnijder, F. Penninckx, Leuven

16.00  Break
Belgian Section for Abdominal Wall Surgery

**Thursday, May 2nd**
16.30-18.30  Auditorium

**Postoperative Groin Pain after Inguinal Hernia Repair**

Moderators:  
B. Dillemans, Brugge  
J. Lerut, Bruxelles

16.30  How to prevent postoperative groin pain: surgical anatomy, tips and tricks  
E. Totté, Antwerpen

16.50  Ilioinguinal nerve entrapment as an obscure cause of postoperative groin pain: evaluation and treatment  
D. Knockaert, Leuven

17.10  Discussion

**Incisional Hernia**

Moderators:  
P. Hourlay, Hasselt  
T. Vierendeels, Aalst

17.15  Treatment of the giant incisional hernia  
R. Simmermacher, Utrecht, The Netherlands

17.35  Treatment of the parastomal hernia  
P. Verhaeghe, Amiens, France

17.55  Discussion

18.00  **General Assembly**

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Belgian Trauma Society

**Thursday, May 2nd**
16.30-18.00  Magritte Room

**Pitfalls and Complications in Trauma Care: Prevention and Treatment**

Moderators:  
H. Janzing, Venlo, The Netherlands  
S. Nijs, Leuven

16.30  Informed consent in the emergency department  
J. Populaire, Geel

16.45  How to avoid misdiagnosis and mistreatment in the emergency department  
L. Mortelmans, Brasschaat

17.00  The value of standing orders in the emergency department  
F. Somville, Lint

17.15  Pitfalls in geriatric trauma  
S. Nijs, Leuven

17.30  Pitfalls in polytraumatised patients  
P. Broos, Leuven

17.45  Pitfalls in the management of perforating trauma  
A.B. Van Vugt, Rotterdam, The Netherlands

18.00  **General Assembly**
Belgian Section for Colorectal Surgery

Friday, May 3rd
09.00-13.00  Auditorium

Complications after Rectal Surgery
Moderators:  F.J. Slors, Amsterdam, The Netherlands
A. Kartheuser, Bruxelles

09.00  Anastomotic leakage
P. Pattyn, Gent

09.15  Urogenital complications
F.J. Slors, Amsterdam, The Netherlands

Clinical Case Presentations with Discussion

09.30  Faecal incontinence
Presenter:  M. Duinslaeger, Brussel
Discussant:  Cl. Bertrand, Jolimont

10.15  Perineal sinus after rectum excision
Presenter:  P. Pattyn, Gent
Discussant:  L. Deruyter, Oostende

10.00  Pelvic haematoma
Presenter:  D. De Coninck, Brugge
Discussant:  A. D’Hoore, Leuven

10.15  Recto-vaginal fistula after LAR
Presenter:  L. Bruyninx, Liège
Discussant:  J. Van de Stadt, Bruxelles

10.30  Ileal pouch-anal anastomotic stenosis
Presenter:  A. Kartheuser, Bruxelles
Discussant:  C. Jehaes, Liège

10.45  Failed double stapling
Presenter:  W. Vaneerdeweg, Antwerpen
Discussant:  D. Claeys, Gent

11.00  Break

Complications after Colo- or Ileostomy Construction
Moderators:  R. Dozois, Rochester, USA
F. Penninckx, Leuven

11.30  Surgical treatment of stoma complications
R. Dozois, Rochester, USA

Experiences of Stoma Nurses

12.00  Initial experiences with an out-patient clinic for stoma care
A. Vanden Bosch, Leuven
C. Thielemans, Gent

12.10  Skin complications
B. Crispin, Bruxelles
M. Lefort, Bruxelles

12.20  Stoma nurse associations in Belgium
F. Meuleneire (VLAS),
R. Van den Bulck (ABISCEP)

12.30  General Assembly

13.00  Walking Lunch
Belgian Society for Vascular Surgery
Belgian Association for Cardio-Thoracic Surgery

Friday, May 3rd
09.00-11.00  Magritte Room

Surgery of the Thoracic Aorta

Moderators:  F. Vermassen, Gent
            P. Van Schil, Antwerpen

09.00  Surgery of the ascending aorta
       R. Verhelst, Bruxelles

09.24  Aortic arch reconstructions
       R. De Geest, Aalst

09.48  Traumatic aortic rupture
       A. Nevelsteen, Leuven

10.12  Endovascular treatment of thoracic aortic dissection
       C.A. Nienaber, Hamburg, Germany

10.36  Thoraco-abdominal aortic aneurysm
       M. Schepens, Nieuwegein, The Netherlands

Belgian Section for Upper GI Surgery

Friday, May 3rd
11.30-13.00  Magritte Room

Traumasms of the Esophagus

Moderators:  P. Pattyn, Gent
            C. Bertrand, Jolimont

11.30  European surveys on esophageal traumatisms and perforations
       E. Ancona, Padua, Italy

11.45  Conservative management of esophageal perforations
       O. Lemoine, Bruxelles

12.00  Boerhaave’s syndrome: early vs delayed treatment
       T. Lerut, Leuven

12.15  Complete disruption of the cervical esophagus after laser division of a
       Zenker’s diverticulum
       J.-M. Collard, Bruxelles

12.30  General Assembly

13.00  Walking Lunch
Belgian Section for Breast Surgery

**Friday, May 3rd**
14.00-15.30  Magritte Room

**Breast Carcinoma of Limited Extent, Breast Conserving Surgery**

Moderators: B. Carly, Brusel  J.-M. Nogaret, Bruxelles

14.00  How wide is wide? The surgical point of view  
N. Bundred, Manchester, UK

14.20  Breast carcinoma of limited extent, a new entity? Pathologists’ point of view  
D. Faverly, Bruxelles

14.40  Treatment of local recurrences after breast conserving surgery  
H. Oldenburg, Amsterdam, The Netherlands

15.00  General Assembly

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Belgian Section for Hepatobiliary and Pancreatic Surgery

**Friday, May 3rd**
14.00-17.30  Auditorium

**Complications in Pancreatic Surgery**

Moderators: Cl. Bertrand, Jolimont  J.-F. Gigot, Bruxelles  J. Weerts, Liège  D. Ysebaert, Antwerpen

14.00  Pancreatic fistula:  
Technical aspects  
B. Van Hee, Antwerpen

Pharmacological prevention  
J.-F. Gigot, Bruxelles

14.30  GI and pancreatic bleeding  
Surgical aspects  
R. Aerts, Leuven

Endovascular management  
P. Dodelinger, Liège

15.00  Complications of vascular reconstruction  
C. Bertrand, Jolimont  D. Glineur, Bruxelles

15.30  Break

16.00  Delayed gastric emptying  
J. Closset, Bruxelles  M. Gelin, Bruxelles

16.30  Complications after surgical management of necrotising pancreatitis and pancreatic abscesses  
U. Hesse, Gent  B. de Hemptonne, Gent

17.00  Complications of total pancreatectomy  
O. Detry, Liège  P. Honoré, Liège

17.30  General Assembly
Belgian Society for Surgical Oncology

**Friday, May 3rd**
16.00-18.30  Magritte Room

**Postgraduate Course in Oncological Surgery**
Moderators:  I. De Wever, Leuven  
R. Detry, Bruxelles

16.00  Oncogenes: what a surgeon should know  
*Ch. Verellen-Dumoulin, Bruxelles*

**Pitfalls in Oncological Surgery**
16.45  Diagnostic process of soft tissue masses  
*H. Hoekstra, Groningen, The Netherlands*

17.20  Pitfalls in the interpretation of pathology reports by surgeons  
*M. Marichal, Brussel*

17.55  The surgeon as a risk factor in oncological surgery  
*I. De Wever, Leuven*

18.30  **Happy Hour offered by Tyco Healthcare**

20.00  **Gala Dinner**

Belgian Group for Endoscopic Surgery

**Saturday, May 4th**
09.00-10.30  Auditorium

**Complications of Laparoscopic Esogastric Surgery**
Moderators:  *B. Dallemagne, Liège*  
*E. van Vyve, Bruxelles*

09.00  Surgery for gastro esophageal reflux disease Management of early and late intrathoracic migration of the antireflux valve  
*M. Legrand, Huy*

09.20  Surgery for gastro esophageal reflux disease  
Post fundoplication dysphagia: diagnosis and treatment algorythm  
*J.M. Weerts, Liège*

09.40  Laparoscopic gastric resection  
Tips and tricks to avoid complications  
*S. Azagra, Montigny-le-Tilleul*

10.00  Laparoscopic surgery for morbid obesity Management of complications  
*P. Pattyn, Gent*

10.20  Conclusions of the session of the upper GI section of the RBSS on esophageal trauma  
*J.M. Collard, Bruxelles*

10.30  **Break**
Belgian Society for Vascular Surgery

Saturday, May 4th
09.00-10.30 Magritte Room

Junior Meeting

Belgian Section for Endocrine Surgery

Saturday, May 4th
10.45-12.00 Auditorium

Pitfalls in Endocrine Surgery

Moderators: J.-P. Squifflet, Bruxelles
J. Bonjer, Rotterdam, The Netherlands

10.45 Surgical responsibilities in endocrine surgery
L. Proot, Brugge

11.05 The use and misuse of neck dissection for thyroid cancer
B. Carnaille, Lille, France

11.30 Diagnostic and therapeutic pitfalls in primary HPT
B. Van Hee, Antwerpen

11.50 Pitfalls and limits of laparoscopic adrenalectomy
J. Bonjer, Rotterdam, The Netherlands

Royal Belgian Society for Surgery

Saturday, May 4th
12.15-13.00 Auditorium

12.15 General Assembly
Belgian Association for Pediatric Surgery

Saturday, May 4th
10.45-12.15 Magritte Room

Moderators: F. Collier, Bruxelles
T. De Backer, Brussel

10.45 Pediatric liver transplants without corticosteroids
R. Reding, Bruxelles

11.00 Retrospective analysis of a series of 300 newborns with hypertrophic pyloric stenosis
J. Van Gucht, Brussel

11.12 Pitfall in the diagnosis of appendicitis
C. Lagey, Antwerpen

11.24 Laparoscopic surgery in the newborn: toy or tool
M. Miserez, Leuven

11.36 How to decrease general pitfalls in hypospadias surgery
F. Collier, Bruxelles

11.51 Unexpected urogenital pathology in an 8 year old girl after multiple urogenital interventions
K. Schwagten, Antwerpen

12.03 Displaced fractures of the fifth metacarpal: percutaneous pinning under locoregional anaesthesia in the one day clinic
M. Bellemans, Bruxelles

General Information

Date: Thursday, 2nd May until Saturday, 4th May, 2002

Venue: Casino Knokke
Zeedijk Albertstrand 509, 8300 Knokke-Heist
Phone during the congress: 050 63 05 00

Car Park: There are sufficient car park facilities available in the direct neighbourhood of the Casino. Participants will receive a parking voucher together with their confirmation of registration.

Language: The official language of the Congress is English. Simultaneous translation is NOT provided.

Accreditation: An application for accreditation has been submitted (also for ethics).

Liability: In registering for the Congress, participants agree that neither the Congress Committee nor the Organisers assume any liability whatsoever. Participants and sponsors should therefore organise their own health and personal insurances.

Dinner: A very special Dinner will be organised on Friday evening May 3rd at the Casino. The Metropolis Quartet will perform a musical humor show, called ‘Fortissimo’ during the Dinner. Pre-registration is obligatory in order to obtain an entrance ticket.

Organised with grant of:
Registration

Registration Fee (Euro)

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<td>125,00</td>
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Registration includes:

- Participation in the Congress
- The Congress bag containing the programme, the abstract book, certificates and congress documents.
- Lunches, coffee and Happy Hour as indicated in the programme.

Payment

- By bank transfer onto account number 123-6876284-11 of ‘Congress RBSS, May, 2002’
- Bank address: OBK Bank, Graaf v. Vlaanderenplein 19, B-9000 Gent
- SWIFT: BKCPBEBB
- By credit card: all major credit cards are accepted.

Registration

Participants are encouraged to register through the web. The complete programme of the congress and the registration form are available at www.medicongress.com.

Registration forms can also be mailed or faxed to Medicongress, Waalpoel 28/34, 9960 Assenede. fax +32 (0)9 344 40 10

Confirmation

Acknowledgement of registration as well as receipt of payment will only be sent when both the registration form and the payment in full have been received.

Cancellation Policy

- Participants cancelling their registration before March 31st will receive a full refund less €25 administration costs. There will be no refunds for cancellations received after this date.
- Name substitutions are accepted at any time at an extra charge of €15.
- Cancellations must be confirmed in writing to Medicongress.
- All refunds will be made after the congress.

Hotel Accommodation

A number of hotel rooms have been reserved at attractive group rates at the following hotels.

All hotels are located nearby the Casino.

<table>
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<th>Hotels</th>
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<td>Albert Plage***</td>
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<td>Binnenhof****</td>
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<td>Lido***</td>
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Rates are in Euro and include breakfast, taxes and services.

- Any request for hotel accommodation must be indicated on the registration form, and must be accompanied by a Credit Card number in order to guarantee the reservation of the room (rooms have to be paid at check-out).
- Room reservations are confirmed by means of a Hotel Reservation Voucher, sent together with a hotel brochure.
- Rooms are booked on a ‘first come, first served’ basis. Room availability cannot be guaranteed after 15th April.
Sponsors

Aprime
Aventis
Bard Benelux
Baxter BioScience
Baxter NV
B Braun Medical
Bristol-Myers Squibb & UPSA
Duo-Med
Endoscopie R. Wolf Belgium
Erbe Benelux
Johnson & Johnson
Hélioscopie
Mölnlycke
Omnilabo
Patella
Sanofi-Synthelabo
Smith + Nephew
Stöpler Belgium
The Surgical Company
Tyco Healthcare
UCB Pharma
W.L. Gore & Associates
Wisepress

Abstracts
MINIMALLY INVASIVE OBESITY SURGERY: EARLY EXPERIENCE WITH LAPAROSCOPIC GASTRIC BYPASS

Vix M., Ceulemans R., Marescaux J.
IRCAD/EITS, University of Louis Pasteur, Strasbourg, France.

Introduction: In 1997, the WHO (World Health Organization) expert consultation on obesity recognized that being overweight and obesity represent a rapidly growing threat to the health of populations in an increasing number of countries worldwide. Morbid obesity surgery has progressively developed into a surgical entity that has become an appealing treatment modality for this patient population. The minimally invasive approach to this type of surgery has now gained worldwide acceptance and has become the treatment of choice secondary to patient demands. Although laparoscopic gastric banding exceeds all other procedures in terms of numbers, the laparoscopic bypass is at present the most frequently performed minimally invasive procedure for the treatment of morbid obesity in the U.S.A. and remains the benchmark to which other operations are compared, for evaluation of their quality and effectiveness. Laparoscopic gastric bypass is now gaining increasing interest in France and Europe but is not yet commonly performed. The aim of this presentation is to report the results of our early experience with laparoscopic Roux-en-Y gastric bypass (LGBP).

Methods: Since November 2000 a LGBP has been proposed to all patients with a BMI exceeding 45 kg/m₂. All patients receive the same preoperative workup. An isolated 25 ml gastric proximal pouch is created using two linear staplers while a 25 mm circular stapler (Premium Plus CEEA Tilt-Top Tyco/Autosuture,) with a tiltable anvil completes a Roux-en-Y gastro-jejunostomy to this pouch. The length of the duodenojejunal limb measures 50 cm and the gastrojejunal limb 100 cm. If the BMI exceeds 60 kg/m₂, one case in our series, the limbs are lengthened to 100 and 150 cm respectively. A routine contrast swallow is performed after surgery on the second postoperative day. The standard follow-up schedule consists of outpatient visits at 1 week, 3 weeks and monthly thereafter. All operative and postoperative data are entered into a prospective access database.

Results: From November 2000 to February 2002, fifteen patients were entered in this database. The mean preoperative BMI was 53 kg/m₂ (range 46-63). Eight patients (53%) were superobese (BMI >50, >225% ideal weight). One patient had a LGBP after gastric band erosion. Six patients had one or more co-morbidities including sleep apnoea (2), hypertension (2) and type 2 diabetes (2). There were no conversions, no intraoperative complications and there was no mortality. Intra-hospital postoperative morbidity occurred in 4 patients (26.7%). One haemorrhage was encountered at the staple line of the gastric remnant requiring laparoscopic exploration and haemostasis. One anastomotic leak, diagnosed on the routine contrast study and completely asymptomatic, was treated conservatively. One patient had a wound infection. The mean hospital stay was 7 days (range 5-15 days). One patient required endoscopic injection of adrenaline for bleeding at the pouch staple line as an outpatient, 8 days postoperatively. Between 2 and 3 months after surgery 5 patients (33%) developed a stenosis of the gastrojejunalostomy requiring one or two endoscopic dilatations. At 6 months follow-up the average excess weight loss was 59% (range 47%-74%) and the mean BMI 36 kg/m₂ (range 31-48 kg/m₂). Co-morbidities improved significantly or were completely resolved.

Conclusion: The results of this early experience compare favourably with those published in larger series. The risk of stenosis is similar to the reported risk in series using the 25mm circular stapler. Although the follow-up is only short term at present, excellent results in terms of weight reduction and treatment of co-morbidities can be achieved with LGBP.
HOW TO HAVE ADEQUATE EXPOSURE IN LAPAROSCOPIC COLORECTAL SURGERY

Leroy J., Ceulemans R., Marescaux J.
IRCAD/EITS, University of Louis Pasteur, Strasbourg, France.

In laparoscopic colorectal surgery two principle techniques of exposure can be described: one for right colectomy and one for left colectomy, sigmoidectomy or colorectal resection.

Preoperative preparation
The preoperative bowel preparation is the first and a very important step of good exposure. A fibre free diet is prescribed starting 8 days before surgery. Polyethylene glycol is then administered 2 days prior to surgery.

Right colectomy
The team positioning and trocar placement are shown in figure 1 and 2. The patient is positioned in 15 to 20 degrees antitrendelenburg and a 10 degrees left lateral tilt. Curarization or adequate muscle relaxation and a pneumoperitoneum pressure of 12 mmHg is usually sufficient to create optimal working space. If required antispasmodic medication can be added to prevent the bowel from moving after adequate positioning. For procedures of more than 1.5 to 2 hours it is recommended to avoid the use of nitrous oxide that may cause the colon to bloat and bulge. The omentum and transverse colon are retracted towards the left subphrenic space and held with an atraumatic grasper while gravity allows the small bowel to fall down from the operative field.

Left colectomy, colorectal resection
The team positioning and trocar placement are shown in figure 3 and 4. The patient is positioned in 20 to 30 degrees Trendelenburg and 10 degrees right tilt. The intra-abdominal pressure and issues concerning the use of antispasmodic medication and nitrous oxide are identical. The greater omentum and the transverse colon are positioned in the left subphrenic region while the proximal small bowel is carefully placed one loop on top of the other in the right upper quadrant using atraumatic graspers. Autostatic retraction is held by a grasper in the left flank, at the level of the mesenteric root. The distal small bowel and the caecum are retracted and held using a grasper positioned at the right upper quadrant that is clamped on the peritoneum at the right iliac fossa. The mesosigmoid is grasped and retracted completing the exposure. Few special cases need to be addressed. Adhesions are only divided if they cause obliteration of the operative field. Adhesions elsewhere may even provide a natural way of exposure. Obesity is seldom a contraindication or problem if a medial approach is used during the dissection. In a female, the uterus may be retracted using a stitch through the fundal portion of the uterus or using a flexible retractor.
LAPAROSCOPIC LEFT COLECTOMY AND ANTERIOR RESECTION OF THE RECTUM FOR CANCER: CARCINOLOGIC RULES

Kartheuser A., Mourad M.
Colorectal Surgery Unit, Cliniques Universitaires Saint-Luc – UCL, Brussels, Belgium.

Laparoscopic colorectal surgery for cancer should strictly follow the same carcinologic rules as conventional open surgery.

As a first step, a complete abdominal exploration and resectability assessment must be performed.

Particular attention should be paid to the tumour site and size, serosal invasion, lymph node enlargement, the presence of ascites, peritoneal seedings and liver metastases.

For every lesion deemed to be suspicious, a biopsy must be taken.

The first rule is the no-touch technique of Turnbull: avoiding grasping the colic wall or touching the tumour itself throughout the procedure by using the pericolic fatty appendages instart.

As soon as the tumour has been identified, preliminary isolation of the tumour-bearing colic segment should be performed between tapes.

The next step be preliminary inferior mesenteric vessel ligation with sympathetic plexus preservation.

After complete colorectal mobilization, rectal wash-out is performed with a cytocidal agent, such as isobethadine.

The pelvic cavity should also be irrigated for a few minutes with the same cytocidal agent.

The tumour-bearing colic segment is extracted from the abdominal cavity through a short suprapelvic laparotomy with protection of the abdominal wall by a plastic covering.

Finally, colorectal anastomosis is performed with a circular stapler.

HPT1 AND MULTIPLE GLAND DISEASE

Maweja S, Henry J.F.
Dept. of Endocrine Surgery, CHU la Timone, Marseille, France.

As a reminder

The standard surgical treatment of HPT1 is well known. There are 3 general principles that we follow: first to explore both sides of the neck, second to find at least 4 glands, third to preserve normal parathyroid glands. The surgeon must remove the abnormal gland or glands. All the difficulty is the location of the four glands and most importantly the location of the abnormal gland. The location of parathyroid glands varies widely as a result of differences in degree of migration during the embryologic development. More over, there is a natural displacement of the enlarged glands, that migrate as a result of gravity. About 85% of HPT1 are due to a solitary enlarged gland. Therefore, multiglandular disease is observed in 15% of cases.

We are going to discuss a case of multiple gland disease that is illustrated by a film.

Exploration of the neck:

We performed a symmetric collar incision 2 cm above the clavicles. We incise the platysma and dissect the platysma flap upward to the notch of the thyroid cartilage and downward to the suprasternal notch. A midline incision is made in the cervical fascia, the strap muscles are separated from the underlying thyroid and thymus. Then, we open the fascia between the carotid artery and the thyroid to access to paratracheal and paraoesophageal areas. Afterwards, the thyroid is retracted medially and anteriorly.

Throughout the procedure, the surgical field must be as bloodless as possible to prevent discoloring parathyroid glands. The first step is the location of the four glands. The dissection should be done under direct vision of the recurrent nerve to prevent its injury.

The parathyroid exploration is begun here on the left side, the upper pathyroid or PIV is usually posterior, located behind or on the dorsum of the thyroid, above the inferior thyroid artery. Parathyroids glands are usually surrounded by fat so any lobule of fat at the predilection area should be inspected. The search for the inferior gland or PIII should be started at the lower pole of the thyroid then in the thyrothimic ligament and then in the thymus. This gland is anterior.

All 4 glands should be discovered and assessed in size, color, shape and consistence before any resection.

In this case, all parathyroid glands were enlarged. So we perform a subtotalpara-thyroidectomy leaving only 50 mgr of parathyroid tissue behind to prevent recurrence and post operative hypoparathyroidism.
We recommend preparing the remnant you wish to leave behind before you perform the resection of the others glands. So that, if there is any doubt about the viability of the remnant this gland should be removed and another one should be chosen and so on.

We chose to leave the gland that is the least abnormal appearing and away from the recurrent nerve. We mark the gland by a non absorbable suture to facilitate a potential reoperation. Finally the thymus should be removed bilaterally because a supernumerary parathyroid gland is located in the thymus in 3 to 22%.

At the end of the operation, the operative field is thoroughly checked for hemostasis. The strap muscle and the platysma are closed and the skin is closed intracutaneously. Drainage is not systematic.

ZENKER’S DIVERTICULUM: AN OPEN APPROACH

Lerut T., Coosemans W., De Leyn P., Nafteux P., Van Raemdonck D., Decker G.
Dept. of Thoracic Surgery, University Hospital Leuven, Belgium.

This video shows in detail the technique of diverticulopexy and extramucosal myotomy of the cricopharyngeus and the upper cervical striated muscle through a left cervicotomy. This method is our technique of choice. Patients are indeed allowed to start all feeding the day after the intervention. The vast majority of the patients is able to leave on the second postoperative day. Postoperative complications are minimal.

Our experience in the treatment of Zenker’s diverticulum deals with 297 patients. Thirty six patients have been treated by simple diverticulectomy. In this group at long term follow-up symptomatic recurrence was seen in 2 patients. Barium swallow showed a recurrence of spastic ring like indentation at the level of cricopharyngeal muscle in another 5 patients.

Eleven patients have been treated by the more recently introduced videoscopic diverticuloesophagostomy using the modified endo GI staple device. Two patients required reoperation. Nine patients at the final evaluation had excellent or good outcome. Two patients had a fair outcome with residual difficulties in swallowing. Patients treated with diverticulopexy and extramucosal myotomy (250 patients) had excellent or very good results in 96.6% of the patients. A subset of 28 patients was followed for up to 10 – 19 years. All patients were totally asymptomatic.
Thursday 2nd May 2002
RBSS
How I do it

How to perform a gastro-jejuno-colostomy.
Pierre MENDES da COSTA
Clinique de Chirurgie Digestive et Coelioscopique
C.H.U. Brugmann - BRUXELLES

<table>
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<td>Laparotomy</td>
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PRECAUTIONS

- No traction
- No parietal hematoma
- Good vascularization
- Not too much fixation
- Good parietal closure

STOMIES COMPLICATIONS

- Retraction
- Stenosis
- Hemorrhage
- Prolapsus
- Eventration
- Infection (cutaneous)
LE MEDECIN A-T-IL ENCORE DROIT A L’ERREUR EN 2002?
LE POINT DE VUE DES ASSURANCES

Bolland M.
Secrétaire Général de la SMAP

Deux points seront développés:

a) dans l’état actuel de la législation, quel niveau de protection un contrat d’assurance peut-il fournir au médecin ?

Seront plus particulièrement examinés les points suivants:

- la responsabilité pénale
- la responsabilité civile
- la protection juridique
- le mécanisme de détermination des primes

Ce point se terminera par l’identification des problèmes clés posés par le cadre juridique actuel:

- épée de Damoclès sur la tête des médecins (le niveau des primes)
- pratiques de médecine défensive

b) quelles propositions peut-on formuler pour améliorer le cadre juridique?

- état des travaux du groupe de travail interministériel
- propositions des assureurs
- vers une responsabilité sans faute? limitée? financée par qui?
- quelques considérations éthiques et pratiques: comment donner à la médecine un cadre juridique moderne, tout en préservant les droits des patients? comment trouver un financement juste et équitable?

THE MEDICAL RESPONSIBILITY:
CURRENT VIEW FROM THE COUNCIL OF PHYSICIANS SIDE

Squifflet J.-P.
Dept. of Kidney and Pancreas Transplantation (Chairman), Cliniques UCL Saint-Luc, Brussels, Belgium.
Council of Physicians. Province of French Brabant (Chairman), Brussels, Belgium.

The medical responsibility has been clearly defined in the Royal Decree n° 78 dated November 11, 1967 concerning the medical practice. Moreover, several articles from the Ethical Code (Code de Déontologie) have clarified some social and economical responsibilities in the medical practice (articles 99 to 103) and the quality of patient care (article 36). The National Council has also published at least 31 advises facing the daily reality and the growing insecurity. That atmosphere is coming from the jurisprudence, the increasing responsibility insurance fees, the obligation of results instead of means, and the project of patient rights law. That project is currently dissociated from other projects such as an update on the medical responsibility and/or the no fault indemnity.

Therefore, there is a current need for developing patient information and using informed consent forms for risky surgical procedures. Before recognizing the no fault concept with indemnity, it is necessary to review the coverage of the responsibility insurance, educate the medical doctors in the no fault concept, study the mode of compensation for therapeutic hazards and differentiate the objective and subjective parts of the patient’s chart.
EVOLUTION RECENTE DE LA JURISPRUDENCE DANS LE DOMAINE DE LA RESPONSABILITE MEDICALE

Muylaert P., Brussel

Les procédures contre le corps médical connaissent incontestablement un regain nouveau. Des organismes spécialisés (asbl Erreurs Médicales) centralisent les plaintes des patients. Ces asbl ont des liens étroits avec certains cabinets d’avocats spécialisés, ainsi qu’avec certains médecins de recours. La crainte du procès a créé dans le chef du médecin une attitude nouvelle «la prudence extrême et la multiplication des avis médicaux». En réalité, c’est le climat de confiance entre le patient et le médecin qui se trouve ainsi gravement affecté. A cela, il faut ajouter un courant de jurisprudence extrêmement défavorable, inauguré par l’arrêt de la Cour de Cassation de France du 25 février 1997, qui a littéralement renversé la charge de la preuve de la faute médicale. Dans certains domaines, notamment dans le domaine des maladies nosocomiales, on assiste à un glissement d’une obligation de moyen vers une obligation de résultat. Par ailleurs, des dommages «nouveaux» sont apparus. Certains patients n’hésitent pas à postuler la réparation d’un dommage du chef de la naissance d’un enfant. Le législateur français a réagi face à l’arrêt «Perruche».

Qu’en est-il en Belgique ? L’introduction de documents écrits «formulaire de consentement éclairé» doit constituer une protection supplémentaire pour le corps médical face aux revendications abusives de certains patients. Le contrat médical demeure avant tout un contrat de confiance et le dossier médical doit constituer l’élément fondamental pour l’établissement de la preuve. La responsabilité du médecin doit être appréciée à la lumière d’une obligation de moyen et non pas d’une obligation de résultat. La différence est fondamentale au niveau de la charge de la preuve.

En effet, le créancier d’une obligation de moyen doit démontrer que le résultat escompté n’a pas été atteint en raison d’une faute ou d’un défaut de diligence. Il doit en outre apporter la preuve du lien de causalité entre cette faute et le dommage subi. Par contre, le créancier d’une obligation de résultat doit uniquement prouver l’absence d’obtention du résultat.

Dans cette hypothèse, on présume généralement la responsabilité.

Dans cette dernière hypothèse, le médecin ne pourra dégager sa responsabilité qu’en démontrant l’existence d’une force majeure ou d’une cause étrangère.

Un tel glissement de la jurisprudence n’est pas acceptable et fort heureusement la Cour de Cassation en Belgique, dans son arrêt du 14 décembre 2001, a rappelé le principe général de la preuve qui incombe toujours au patient.
INTRAPERITONEAL IMPLANTATION OF PTFE PROSTHESIS: EFFECT OF THE SIDE ON ADHESION FORMATION IN AN EXPERIMENTAL ANIMAL MODEL

Chamlou R., El Nakadi I., Rahier I., Melot C., Gelin M., Limbosch J.M.

Introduction
Various prosthetic materials have been used for the surgical management of major abdominal wall defects or incisional hernias. One such agent, polytetrafluoroethylene (PTFE) (Teflon, : C.R. Bard Incorporated, Murray Hill, New York), composed of carbon and fluorine, has one irregular and one regular side, raising the possibility of a potential difference in adhesion formation between the two sides. The purpose of this study was to determine if the intraperitoneal positioning of the PTFE prosthesis has an influence on the formation of postsurgical adhesions to abdominal structures.

Methods
Sixty female Wistar rats were randomly divided into three groups: group I: control group (n=12) undergoing sham operation (open/closure); group II: intraperitoneal implantation of PTFE with regular side positioned upwards (n=24); group III: intraperitoneal implantation of PTFE with irregular side positioned upwards (n=24). Six animals from each of groups II and III were sacrificed at 3, 8, 12 and 14 weeks, respectively, after implantation. Histological evaluation of the meshes included assessment of the degree of inflammation, granuloma, fibrosis and mesothelial hyperplasia. Macroscopic adhesion formation was also assessed. Nonparametric statistical analysis of Mann-Whitney were used to compare results.

Results
Microscopic results: the prosthetic reaction to the abdominal wall was the same for both groups. The only significant findings were a higher incidence of fibrosis at three weeks (p<0.03) and of granuloma at 14 weeks (p<0.03), in group II than group III animals. Macroscopic results: there were no significant differences in adhesion between the prosthesis and the abdominal wall among the two implant groups. Adhesion of the prosthesis to the great omentum was constant in both groups with no statistically significant difference.

Conclusions
Despite a physical difference between the two sides of PTFE mesh, there were no differences in terms of macroscopic adhesion formation nor histological evaluation in this rat model.

IMPLICATIONS OF PREPERITONEAL MESH IMPLANTATION IN THE TREATMENT OF INGUINAL HERNIA

Lauwers P., Hubens G., Vaneerdeweg W.
Dept. of Abdominal Surgery, University Hospital of Antwerp, Edegem, Belgium.

Introduction
More and more prosthetic materials are being used in the treatment of inguinal hernia. This case report deals with an unusual but devastating complication, occurring after preperitoneal mesh implantation.

Case report
A 56-year-old male patient underwent a Stoppa-repair for a bilateral inguinal hernia. Two years postoperatively, he was transferred to our department because of a painful mass in both groins. On ultrasound and CT-scan, this proved to be an inflammatory mass which was punctured and treated with antibiotics.

A few months later, he was readmitted with the same complaints. A new CT-scan revealed a tumoral mass involving the sigmoid colon. A sigmoidectomy was performed, with an uncomplicated recovery; part of the Stoppa mesh was removed during the same procedure. Malignancy was ruled out by histology; however, the microscopic report mentioned the presence of a marlex mesh.

Another two years later, he again developed a painful mass. Once again, CT-scan demonstrated an inflammatory process, now involving the bladder wall. Cystoscopy and cystography could not determine the character of this lesion and another laparotomy was scheduled. Ingrowth of the prosthesis into the bladder wall was the unfortunate finding; the prosthesis was resected and the defect in the bladder closed.

The patient needed two more interventions because of recurrent abcedation. All the remaining of the mesh has been removed and all wound fistulas have been excised widely. Nowadays, the patient is recovering well with complete healing of all wounds.

Conclusion
Although infection of prostheses used in the treatment of hernias has been described, late and serious complications related to mesh implantation, such as perforation of intraabdominal located viscera, have been reported seldom.
LAPAROSCOPIC VERTICAL BANDED GASTROPLASTY AVOIDING STAPLING IN CONTINUITY [LVBG]: A RETROSPECTIVE EVALUATION OF OUR FIRST 31 CASES

Deleersnijder R., D’Hoore A., Penninckx F.
Dept. of Abdominal Surgery, University Clinics, Gasthuisberg, Leuven, Belgium.

Open vertical banded gastroplasty [VBG], as described by Mason, is a frequently used technique in bariatric surgery. Major morbidity after this procedure occurs in 4.2% and consists of abdominal wall infection and dehiscence, thromboembolic events and rarely life threatening peritonitis. Late stapline disruption, banderosion and incisional hernia are the main causes for reoperative surgery. We report our first experience in LVBG and how this technique mainly avoids the major morbidity described after VBG.

Between October 2000 and November 2001, 31 patients [7 male, 24 female] underwent LVBG. The mean age was 36 yrs [18-53]. Their preoperative average weight and BMI were respectively 117± 16 kg and 42±4 kg/m². All were bulk eaters and were screened preoperatively for psychological or endocrine disorders. Laparoscopic procedure was performed in steep Fowler position. Using a 37 Fr nasogastric tube as a calibrator and a modified Babcock, a window was created 7 cm below the angle of Hiss using the pCEEA 25 mm stapler. The vertical pouch division is constructed using at least two firings of the EndoGIA 60. The pouch outlet is reinforced using a silastic ring of 55 mm.

During the study period only one patient had to be converted due to stapler failure. Operating time progressively decreased from 83±10 minutes in the first ten cases to 62±7 minutes in the last ten cases. Mean hospital stay was 5.7 days [4-20]. All patients underwent a control gastrografin swallow on day 3, no leak was visualised. A fluid based diet and LMWH were given for 3 weeks. In the early postoperative period one patient developed a catheter sepsis [Staph Aur]. Late morbidity occurred in 5 patients. Two patients developed oesofagitis treated with PPI. One presented 1 month after surgery with a Streptococcus sepsis secondary to sludge cholecystitis. Two patients developed a pouch outlet obstruction with complete solid food intolerance. They needed re-laparoscopic surgery to enlarge the silastic ring with 1 cm. Six months after surgery, the average weight and BMI reduced with 30% to 83±13 kg and 29 ± 2.8 kg/m² respectively.

In conclusion, the LVBG is a feasible and safe procedure, resulting in a weight reduction comparable to the open approach and the lap banding procedures.

ILIO-INGUINAL NERVE ENTRAPMENT AS AN OBSCURE CAUSE OF POSTOPERATIVE GROIN PAIN: EVALUATION AND TREATMENT

Knockaert D.C.
General Internal Medicine, Gasthuisberg University Hospital, Leuven, Belgium.

The ilio-inguinal nerve entrapment syndrome was initially described in 1942 and “rediscovered” in the 1980’s and 1990’s. Recently, the syndrome got particular attention as a potential side effect of laparoscopic hernia repair.

Entrapment may develop as a complication of surgical procedures such as appendicectomy, classical or laparoscopic hernia repair, Pfannenstiel incision (Caesarean section and hysterectomy) and after blunt abdominal trauma. It has also been reported as a cause of lower abdominal pain in athletes, and a so-called idiopathic form is seemingly not so rare.

The diagnosis may be established when a typical clinical triad is present. This triad consists of 1) a muscular type iliac fossa pain with a characteristic radiation pattern, 2) an altered sensory perception (hyper-, hypo- or dysesthesia) in the involved innervation area (the lower fossa) and 3) a narrowly localized trigger point medial and below the anterosuperior iliac spine. Electromyographic abnormalities are present in 60 % of the cases but the specificity of this technique is not known. Definite diagnosis is established by relief of pain by infiltration with a local anesthetic.

Initial treatment may be conservative and consists of reassurance and explanation of the origin of the pain and infiltration with local anesthetics at the trigger point. In a number of cases, neurolysis at the entrapment area or neurectomy proximal to the entrapment may be necessary to ablate symptoms.

Knowledge of this syndrome may prevent medical shopping with unnecessary gastrointestinal, urological, gynaecological and orthopedic investigations.
INFORMED CONSENT IN THE EMERGENCY DEPARTMENT

Populaire J.
A.Z. St. Dimpna, Geel, Belgium.
Dept. of General Surgery-Traumatology; Medico-legal Adviser

The medical world (in the emergency department) has advanced in recent years as proven for example minimal invasive keyhole and traumatology techniques. On the other hand, however, despite these medical advances, the question of doctor's liability is increasingly becoming an issue. No need to explain that the first cause of this is that the patient has come of age, and he certainly no longer shrinks from accusing his doctor-specialist of malpractice, i.e. holding him liable, when for some reason a medical treatment does not produce the expected result. The number of liability claims is increasing, and that is the result of what can be called the demystification of the medical profession, which is also coupled to the spectacular increase in the number and type of medical services.

When dealing with the liability of a doctor (at the emergency department) we can refer to three forms of liability: civil, criminal and disciplinary. Liability is in a crisis; there may be a solution in the form of objective "no-fault" liability, a concept that has been realised on paper to a greater or lesser extent i.e. the Belgian Association of Doctor Unions clearly tells us that the bill on this no-fault professional liability will soon be submitted to parliament together (?) with the so-called "patient's bill of rights", chapter 2: rechten van de patient-droits du patient (art. 5-11). Professional liability covers the contractual liability (the informed consent aspect) and the extra-contractual liability (obligation of resources).

Besides the general aspects on “informed consent” (that every doctor-specialist and trainees-assistants should realise and know) more specific problems on patient's admission at the emergency department will be discussed. A good and intelligent policy in patient-doctor relation with optimal informed consent will guard us from unpleasant surprises.

What about this Doctor's Statement: “I confirm that I have explained the investigation, treatment or operation to the patient, together with the important risks and possible alternatives. I have also explained what anaesthetic or sedation may be needed, and the purpose, nature and possible problems of the procedure. This information has been given in a form which, I think, the patient understands, has thought about, thinks is relevant and will remember.”

TREATMENT OF LARGE ABDOMINAL WALL DEFECTS WITH THE COMPONENTS SEPARATION METHOD (RAMIREZ)

Simmermacher R.K.J. (1), van Geffen H.J.A.A. (2), Van der Werken Chr. (1)
(1) GZG, Dept. of Surgery,'s-Hertogenbosch, The Netherlands.
(2) Jeroen Bosch Ziekenhuis, UMCU, Dept. of Surgery, Utrecht, The Netherlands.

Introduction: Treatment of patients with large abdominal wall defects, not amenable to primary closure, is still challenging. Despite improved surgical techniques and prosthetic material, no uniform solution is at hand. For patients with large (width > 7 cm and total surface > 50 cm2) defects, the components separation method has been our treatment of choice during the last 10 years. Applicability and limitations were retrospectively studied.

Patients: Sixty-seven patients (m/f = 35/32) with a mean age of 55 years (30-79) and a mean defect of 222 cm2, were treated during the last 5 years. The degree of contamination was NRC-III in 20 cases because of gastrointestinal-tract opening. In 4 cases there was NRC-IV contamination due to abscesses. During 11 operations a gastrointestinal anastomosis was performed.

Methods: After complete adhaesiolysis and removal of all residual prosthetic material (n=11), the components separation method was performed in 44 patients (5 unilateral). In 23 patients a sublay mesh was applied for augmentation.

Results: Thirty-six patients had one or more complications, of which 8 needed a reoperation. Wound infection (15), respiratory failure (8), seroma/haematoma (8), long lasting ileus (6) en enterocutaneous fistulation (4) were the most frequent. One patient died of anastomatic leakage, intra-abdominal sepsis and subsequent M.O.D.S. Another patient died after 4 days due to massive pulmonary embolism. In all 23 patients with augmentation (of which 5 had NRC-III contamination), only one wound infection occurred. At a median follow-up of 12 months, 5 recurrences were found (all non-augmented patients). Two of them were treated conservatively, 2 had an augmentation and one needed primary closure.

Conclusions: In the light of the grotesque pathology, the components separation method has reasonable results. Precaution should be taken because of the high morbidity and even mortality. Contamination up to NRC-III does not exclude the use of prosthetic material.
THE VALUE OF STANDING ORDERS IN THE EMERGENCY DEPARTMENT

Somville Fr.
Head of the Emergency Dept., O.L.V. Middelares, Deurne (Antwerp), Belgium.

In our society information is one of the most important elements required to effectively complete a task. This information must be readily available. The format must be easy to understand, concise and user-friendly. In order to achieve these objectives we researched national and international systems applied in university teaching departments as well as non academic departments, large and small. Information contained in handbooks, pocket guides and computer systems was studied.

The following points were noted:
1) A written text must be available 24 hours a day at the emergency department.
2) The information must be contained in a small handy book (pocket guide), folder / file or computer system.
3) The information should be in concise text with flow charts and diagrams.
4) It is essential that these protocols are regularly revised and updated.
5) While using these protocols it is necessary for the attending emergency doctors never to forget to treat with the appropriate remedy (treatment) applicable to the situation. A good emergency department doctor should use the protocols as a treatment guideline without ignoring their own thorough assessment of the specific situation.
6) Never forget the words: "Think before you act" (Look before you leap).

PITFALLS IN POLYTRAUMATIZED PATIENTS

Broos P.
U.Z. Gasthuisberg, Dept. of Traumatology, Leuven, Belgium

The prognosis of the multi-trauma patient is largely dependant on the availability and quality of the ER personnel. In the present discussion, we elaborate on those factors necessary for adequate trauma care and we discuss notorious pitfalls in trauma care associated with an unfavourable clinical outcome in these high-risk patients. The necessity for experienced personnel working under an implemented protocol is outlined, as is the correct use of diagnostic tools and immediate intervention when encountering life-threatening pathologies. Special attention is given to pathologies whose recognition, as life-threatening can be difficult, implying serious repercussions if overlooked. It is only when certain criteria are met, in a hospital with sufficient day-to-day trauma experience, that quality multi-trauma care can be delivered, minimising the risk of mistakes with serious medical and judicial consequences.
PITFALLS IN THE MANAGEMENT OF PERFORATING TRAUMA

van Vugt A.B.
Dept. of Traumatology and Emergency Care, Erasmus Medical Centre Rotterdam (EMCR), Rotterdam, The Netherlands.

In Western Europe the most frequent cause of multiple injuries is blunt trauma. Only few of us have experience with penetrating trauma, without exception far less than in the USA or South-Africa. In Rotterdam the EMCR is a level I trauma centre, situated directly in the town centre. All penetrating trauma’s are directly presented to our emergency department by a well organised ambulance service and mobile medical team. The delay with scoop and run principles is very short for these cases, which results in severely injured reaching the hospital alive in increasing frequency.

In treatment of penetrating trauma there are several pitfalls.

1. Acute phase: life saving procedures
2. Diagnostic work-up
3. Indications for operative intervention

An simple algorithm can be helpful, especially in case of limited experience.

In case of life saving procedures the principles of Damage Control Surgery (DCS) must be followed. This approach is somewhat different from “normal” surgical treatment. In the 1st phase prompt interventions by emergency thoracotomy and laparotomy are carried out, only with two goals to achieve: surgical control of haemorrhage and contamination. After temporary life saving procedures, perfectly described in chapter 39 of Mattox textbook, the 2nd phase is characterised by intensive care treatment, dealing with hypothermia, metabolic acidosis and clotting disturbances due to multiple transfusions. Finally in the 3rd phase, within 6-24 hours, definitive surgical care can take place.

Stable vital parameters should result in a correct work-up according to ATLS® principles. History and physical examination remain the corner stones of good medical praxis.

Airway, breathing and circulation (including signs of cardiac tamponnade) should be evaluated with great cared. Neurological examination related to trauma of the spinal cord, plexus brachialis and peripheral nerves should be carried out as well as vascular involvement in neck- and extremity injuries. In penetrating trauma the localisation of stab-wounds, inshot- and outshot openings are the main goal to explore. Physical examination should include the flanks and back-side as well as recto-vaginal examination and inspection of the oropharynx.

In the emergency room standard X-rays of neck, thorax, abdomen and pelvis are mandatory with marking the inshot and outshot openings. Lateral views can be helpful. A bullet traject can be diagnosed accurately by these simple means. In case of stab-wounds an abdominal ultrasound should be included in the routine diagnostic work-up. CT-scan with iv-contrast (CTA) are helpful in all cases were the question conservative versus operative can not be answered yet. In case of injuries in the neck or traversing mediastinal injury gastrointestinal contrast should be added to the diagnostic imaging by conventional X-rays or CT-scan. In all cases of penetrating injury of the perineal region and pelvic region a retrograde urethro-cystography is easy to perform and excludes or shows damage of the urethra and/or bladder. Doppler US is helpful in case of vascular involvement. Not only obstruction of the arterial blood flow, but also pseudo-aneurysms or AV-fistula’s can be detected by non-invasive means.

Highly specific are diagnostic means like laryngoscopy, bronchoscopy, and trans-esophagel echo-cardiography, which should be carried out on demand in specific cases.

Indications for primary operative intervention in the neck are diagnosis like major tracheal involvement, injury of the esophagus, expanding haematoma due to vascular injury and in stab-wounds with neurological deficit at the level of the brachial plexus.

More than 50% of all injuries can be treated conservatively. Thoracotomy, either by lateral approach or median sternotomy are indicated is case of persistent air leak (bronchial rupture, lung laceration), haematothorax with ongoing bleeding, cardiac tamponnade and leakage of the esopagus. 70-75% of all penetrating injuries of the thorax can be treated conservatively or by simple procedures such as a thoracic tube-drainage. In case of stab wound below the level of the nipple: be aware of abdominal injury!

Laparotomy is mandatory in all proven intra-abdominal gun-shot wound. In stab-wounds over 50% can be treated without surgical intervention, observed on inpatient service for at least 24 hours. Bleeding with stable circulatory parameters is not an indication for laparotomy! A patient complaining of abdominal discomfort 6 hours after being stabbed in the abdomen, flank or back is at very high suspicion for bowel perforation and should undergo laparotomy without exception. Especially limited spilling due to perforation of the retroperitoneal structures such as colon ascends and descendens are well known silent killers with high morbidity and prolonged disease in case of initially missed diagnosis!

In case of extremity injuries combined treatment of fractures (Gustillo III compound!!), neurovascular impairment and soft tissues is complex, especially in high energy impact. Adequate debridement and fasciotomy should be carried out in these cases.

Some clinical examples are shown:

1. gunshot wound of the neck
2. gunshot wound of the thorax and mediastinal involvement
3. stab wound of the flank-abdomen.
4. gunshot wound with III C fracture of the right femur

Aspects of emergency care, diagnostic work-up and pitfalls will be demonstrated in these cases.
ANASTOMOTIC LEAKAGE

Pattyn P.
UZ Gent, Belgium.

A study of anastomotic leak is critically important to surgeons because morbidity and mortality increase many fold in the aftermath of an anastomotic disruption. A lot of studies have attempted to identify significant factors contributing to leakage of intestinal anastomosis. They used animal models or have an allied retrospective data using univariate analysis. The objective of this talk is to identify factors contributing to leakage of rectal anastomosis. The overall rate of anastomotic leakage is 3.4% in a study of Gorlub R. (Journal of the American College of Surgeons 184: 4 364-372, April 1997). No difference was found in rates of leakage among different techniques of anastomosis or among different anastomotic locations. Colonic anastomosis leaked no more frequently than anastomosis with a small intestine. Approximal faecal diversion did not decrease the frequency of leaks. Other studies show that the clinical impact of leaks with a faecal diversion are not so dramatic than without diversion. Especially pelvic sepsis can induce definite incontinence.

A multivariate analysis shows 6 significant predictable variables: serum albumine level of less than 3.0 g/l, use of corticosteroids, peritonitis, bowel obstruction, chronic obstructive pulmonary disease and perioperative transfusion of more than 2 units package red blood cells. The inner hospital mortality rate in patients with and without leaks is completely different (39.3% vs. 7%). It is definitely clear that anastomotic leaks are a independent predictor of mortality.

If adjuvant preoperative radiotherapy is used in patients with rectal cancer, the incidence of superative fistulas are to be considered in detail. The risk of postoperative fistulas is significantly higher after preoperative radiation (Holm, Cancer September 1, 1996, Volume 78 n° 5). Even in the Stockholm II-trial the incidence was higher in radiated patients. This probably due to an increased frequency of infections and development of fibrosis after irradiation in surgery.

Another point to mention in rectal cancer surgery is the mesorectal excision and the acute side effects and complications with or without short term preoperative radiotherapy in combination. In the study of Mareinen (Journal of Clinical Oncology Volume 20 n° 3, February 1, 2002, 817-825) more radiotherapy positive patients received a temporary diverting stoma at the time of the TME-surgery than radiotherapy negative patients did. Slightly more radiotherapy negative patients required a stoma as a result of complications resulting in a not-significantly different overall number of temporary stomas in both groups. A percentage of LAR-patients who showed clinical leakage postoperatively was 11% and was not statistically different for radiotherapy + in radiotherapy negative patients. Leakage was less common in patients with a diverting stoma.

In patients with an end-to-end anastomosis leakage occurred in 16% of the LAR patients whereas only 9% of the patients with a pouch reconstruction experienced anastomotic failure. 80% required a surgical intervention. Anastomotic leakage contributed to the postoperative mortality in 23% of all inner hospital mortalities.

In conclusion: this abstract is only the key point of the talk to underline the importance of the anastomotical leakage after resection of the rectum. A more profound analysis of the risk factors and how to prevent and treat will be presented more in detail.
SEXUAL AND BLADDER DYSFUNCTION AFTER TOTAL MESORECTAL EXCISION FOR BENIGN DISEASES

Slors F.J., van Zuijlen P.P., van Dijk G.J.
Dept. of Surgery and Sexology, Academic Medical Center, Amsterdam, The Netherlands.

PURPOSE: An evaluation was made of sexual and bladder dysfunction combined with quality of life (QoL) score after a proctocolectomy with total mesorectal excision (TME) for benign diseases.

METHODS: An in-depth questionnaire was mailed to all patients (n = 94) who had undergone a proctocolectomy with TME followed by an ileal pouch-anal anastomosis (IPAA) in the period from 1989 through 1994. Seventy-six patients responded (81%) with a mean age of 34 +/- 10.6 years and a mean follow-up of 33 +/- 18.3 months.

RESULTS: Sexual activity, satisfaction and libido were preserved better in males than in females. Severe sexual dysfunction was found in two males (permanent retrograde ejaculation) and in one female (complete vaginal dryness). No severe bladder dysfunction was found, although minor dysfunction, such as stress and urge incontinence, occurred frequently. QoL was significantly increased postsurgery. Moreover, no evident correlation was demonstrated between QoL and sexual and bladder dysfunction.

CONCLUSION: A relatively low incidence of severe sexual and bladder disorders was found following proctocolectomy with TME and IPAA, whereas minor dysfunction was a relatively common finding. Nevertheless, a significant increase was found in postoperative QoL compared to preoperative QoL.

SURGICAL TREATMENT OF STOMA COMPLICATIONS

Dozois R.R.
Mayo Clinic, Rochester, USA.

Ileostomy and colostomy complications are largely similar and may result from a variety of factors including inappropriate location, technique of construction, underlying diseases, patient habitus, choice of appliances etc. Surgically-correctable complications include retraction, prolapse, stenosis, obstruction and parastomal hernia. Other rare complications that may require surgical treatment include peristoma skin problems such as infection, fistula, ulceration(s), varices etc. Finally, certain types of stomas such as the continent ileostomy of Kock may have very specific problems.

Stoma location greatly influences function, acceptance of stoma, choice of stoma appliances, quality of life and management difficulties. The ideal location should be over flat, smooth, unscarred skin, generally overlying the rectus muscle, ideally below the beltline. Consultation with an expert stomatherapist is invaluable to counsel patients, demonstrate appliances, meet other ostomates and mark sites preoperatively.

Technique of construction. Basic principles to avoid potential difficulties include lack of tension, good blood supply, good alignment of skin, fascia, and peritoneum and opening of a proper size.

For an end ileostomy, I prefer to fix the ileal mesentery to the anterior abdominal wall towards the falciform ligament to reduce the risk of torsion, internal herniation and obstruction. Immediate maturation with three sutures placed between the end of the stoma, the ileal seromuscular layer and the subcutaneous tissue to favor mild eversion is best.

For an end colostomy, a similar technique is used except that the segment of colon to be used as a stoma can be brought straight out or intraperitoneally or through an extraperitoneal tunnel. The latter may reduce complications.

Diverting stomas are temporary, can be constructed from the small or large intestine and are often shaped as a loop, over a rod or not.

Complications

Prolapse may occur in 1 to 15% of patients. It may be less likely by proper preoperative site selection, sitting through rectus muscle, proper sizing of opening, fixation of mesentery, excision of redundancy, extraperitoneal placement of colostomy and end stoma. Repair depends on size, progression and patient’s health and may require relocation, use of mesh or simple amputation and resuturing. Parastomal hernias are preventable by the same means mentioned for preventing of
prolapse. Indications for surgery are most often cosmetic although some patients may have obstructive-type symptoms. Acute severe pain may indicate ischemia. Patients with paracolostomy hernia who were irrigating their colon may find irrigation impossible or that the water does not return. Operative options may include local repair (parastomal or intra-abdominal), relocation, use of prosthetic material (peritoneal, preperitoneal or extrafascial).

Retraction results in skin problems, leakage around appliance and may lead to stenosis and obstruction. It may occur in patients who gain much weight. Treatment may be conservative with trial of different pouching techniques, convex appliance, weight loss but often, surgery is necessary as quality of life of patients deteriorates and skin problems worsen. Repair may be feasible locally if sufficient length of bowel is available and skin condition permits or the stoma may need to be relocated.

Other conditions such as skin infections, fistula, ulcerations varices may require the concerted efforts of the surgeon, the stomatherapist, the gastroenterologist and the dermatologist.

The continent ileostomy of Kock requires no external appliance and thus the stoma can be made flush with the skin and located in a less conspicuous site, low on the abdominal wall. It’s complications relate to the nipple valve mechanism and lead to incontinence and/or difficulties intubating. Surgical repair of the existing valve is usually feasible but at times creation of a new valve or even a permanent end stoma may be necessary.

Suggested Reading

OUT-PATIENT CLINIC FOR STOMA CARE

Vanden Bosch A. (1) Thielemans C. (2)
(1) Leuven, Belgium. (2) UZ Gent, Belgium.

Stoma consultation can be regarded as the continuation of the surgical consultation in this respect, and aims at optimal counselling the patient from the initial presentation through the pre- and postoperative period with as ultimate goal the stimulation of self-care. A guideline in this process is a targeted explanation including leaflets, illustrations ..., of ostomy and its physical, psychological and social consequences. Preoperative stoma site determination is the key to proper equipment and prevents a number of complications such as leakage and subsequent skin irritation, location in a skin fold or near a suture, discomfort from clothes, ... Together with the patient, appliances tailored to his or her specific needs will be searched for. Complications are identified and remedied. The patient is advised on hygiene, nutrition and diet, clothing, sports, holidays, and sexuality.

Colostomy patients are informed of the possibility of irrigation and a training programme is devised to instruct them in these procedures. Contact with and follow-up through the home health care service are essential to promote the patient’s independence. Stoma consultation is one of the cornerstones of good stoma management.
PERISTOMAL SKIN DISORDERS

Crispin B. (1), Lefort M.M. (2)
(1) Stomathérapeute, UCL St. Luc, Brussels, Belgium. (2) Stomathérapeute, ULB Erasme, Brussels, Belgium.

One of the most frequent complications in digestive stomas are skin problems. According to Pearl et al, 42% of early complications are skin problems compared to 31% of surgical complications.

Causes, treatment and prevention of peristomal skin disorders, as dermatitis due to contact with faeces, erosion, erythema, excoriation ulcer, scars or appliances problems, will be considered in the presentation.

In order to prevent the occurrence of peristomal skin disorders, it’s necessary to have a good knowledge of stoma care and available appliances but also a good understanding of skin disorders.

But the Enterostomal Therapist role’s don’t stop with these practical problems: the psychological approach is also of major importance, as a key toward the restoration of a good quality of life for the patient!

VLAS, THE FLEMISH ASSOCIATION OF ENTEROSTOMAL THERAPISTS

Meuleneire F.
AZ St-Elisabeth, Zottegem, Belgium.

At the very start of the VLAS there was a double goal. On the one hand we want an improvement in the nursing of ostomates, fistula- and incontinent patients. On the other hand we want to defend the rights of these patients. To achieve this we made some agreements: the edition of a magazine, the organization of a yearly national congress, to aim for a statute for the enterostomal therapist, the national and international exchange of professional experiences, the promotion of the education of all people involved in stoma-, fistula and incontinence care. We also try to give as much information as possible on publications, literature, stoma material and new developments in stoma care.

Although our organization was founded in 1995, it is worthwhile to take a look back on the results. Our magazine has become our professional sign. At the yearly congress we discuss an item of the stoma or fistula care. Each time we welcome approximately 250 enthusiastic participants.

This year we have for the 3rd time a course of stoma care, introducing 40 nurses during 7 days in stoma care. After a successful test every nurse receives a certificate that can help her or him to profile at stoma care.

During the congress of 1998 we focused on the importance of the communication between all persons concerned in stoma care, with the patient as central person. The result of lots of meetings was the introduction of the booklet ‘Stoma wellnesses. This booklet is free for every stoma patient and contains all information on treatment, care, problems, material, experiences etc. The patients keeps this booklet, it has filled out by someone or writes down himself some data. With the booklet ‘stoma wellnesses’ we believe we contribute to the ability of the stoma patient to take care of himself and to a better communication between all people concerned.

In the future the VLAS wants to concentrate on the realization of the goals that are planned. To achieve this, there are several working groups created. The working group ‘education’ focuses on courses, congresses and the magazine. The working group ‘recognition’ focuses on contacts with the authorities. The working group ‘cooperation’ contacts self-help groups, hospitals, doctors, bandagists, stoma companies etc ... We recently started a working group ‘scientific research’.

I hope that this brief presentation gives an idea on the goals, activities and results of our association. We are convinced that all efforts contribute to the improvement of the quality of life of our stoma patients.

As conclusion I’d like to say that the secret of the force of our organization resides in the spirit of an open communication and professional enthusiasm, based on altruistic friendship and trust in each other.
STOMA NURSES ASSOCIATIONS IN BELGIUM

A.B.I.S.C.E.P (Association Belge d’Infirmières en Stomathérapie, Cicatrisation et Plaies)
Van den Bulck R. - RN, ET, MA, Clinical Nurse Specialist Stoma, Incontinence, Wound care, Surgical Department, Clinique Edith Cavell, Bruxelles, Belgium.

The accurate ostomists population in Belgium is not known but should be around 10,000 patients according to the Christian Social Security statistics. During the eighties there was a growing interest in providing care for ostomates, a group of patients with very special needs, both physical and psychological. However, it became clear that not all ostomates received appropriate care during their stay at the hospital, nor the information they needed to regain their autonomy. These shortcomings arose from a lack of experience and training of the nursing staff. The Belgian Association of Nurses in Stomatherapy Incontinence and Wound Care was set up in January 1995 (ABSICEP) and a few months later the first training course for Enterostomal Therapists Nurses started.

The Association main purposes; best quality of patient care, provide an educational program, give the opportunity to learn the latest in stoma, incontinence and wound care, organise congresses on a national and international level and obtain an official status.

SURGERY OF THE ASCENDING AORTA

Verhelst R., El Khoury G.

Nowadays, the versatility of the different techniques of reconstruction of the ascending aorta enables the surgeon to choose the most appropriate operation for every patient regarding various factors like age, diameter of the aorta, structure and function of the aortic valve, type of pathology of the aortic wall, extension of the dilatation to the aortic root, presence of a chronic dissection, etc …

- Indications for surgery should be more liberal in young patients, especially in the presence of marfan disease or other types of myxoid degeneration, mainly because in these cases the aortic root and sinuses are frequently fragilized or dilated, representing a high risk of evolution and complications if not treated appropriately. The surgical treatment of this group of patients frequently consists in a total excision of all diseased tissues followed by a valve sparing reconstruction or Bentall operation depending on the quality of the valve.

- On the other hand, old patients presenting atherosclerotic aorta frequently dilate only the tubular part of the ascending aorta with few or no dilatation of the aortic root and should therefore be treated more conservatively because the risk of complication is less.

If they have to be operated on the procedure is generally more simple, consisting only in a replacement of the ascending aorta with or without aortic valve replacement. The different options are summarized in this table

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<th>Valve</th>
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<th>Sinuses, sino-tubular junction</th>
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<td>Replacement ascending aorta + valve</td>
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<td>Diseased/young patients</td>
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<td>Bentall, pulmonary autograft</td>
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<td>Valve sparing operation</td>
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<td>Valve sparing operation, Bentall</td>
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<td>N (Marfan)</td>
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<td>Enlarged</td>
<td>Bentall, valve sparing operation</td>
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LESSONS LEARNED FROM 20 YEARS THORACOABDOMINAL AORTIC ANEURYSM SURGERY

Schepens M.
St. Antonius Hospital, Nieuwegein, The Netherlands.

OBJECTIVE: to analyse our results of 20 years thoracoabdominal aortic aneurysm (TAAA) repair and to explore the influence of different adjuncts on morbidity and mortality.

METHODS: between 1981 and Jan 2002, 375 TAAA's were repaired: 73 Crawford type I (19.5 %), 173 type II (46.1 %), 87 type III (23.2 %) and 42 type IV (11.2 %). Simple cross-clamping was used in 123 patients (32.8 %) (no adjunct group); left heart bypass combined with staged clamping of the aneurysm was used in 242 patients or extra-corporeal circulation in 10 patients (adjunct group). Intercostal/lumbar arteries were reimplanted freely but since the introduction of motor evoked potentials, this method (since 1995) helped in the decision to reimplant or not. A cerebrospinal fluid drain was inserted in 55.2 % (since 1989). Our actual preferred method is staged clamping with left heart bypass, cerebrospinal fluid drainage, moderate hypothermia, liberal intercostal and lumbar artery reimplantation and motor evoked potential monitoring. Elective repair was performed in 91 % of the patients.

RESULTS: intraoperative mortality was 0.8 % (n=3). Hospital mortality was 8 % (n=30). Renal insufficiency necessitating hemodialysis occurred in 26 patients (6.9 %):13.8 % in the simple cross-clamp group versus 3.6 % in the adjunct group, p=0.001 . Immediate-onset and delayed-onset paraplegia or paraparesis (P/P) occurred in 32 patients (8.5 %): 14 % in the simple cross-clamping group versus 5.5 % in the adjunct group, p=0.004. P/P occurred in 8.9 % of type VII TAAA's and in 7.8% of type III/IV TAAA's (p=0.4). Over the last 5 years P/P rate was 4.2 % and hemodialysis rate was 2.1 %.

CONCLUSION: our results have gradually been improved over the years due to the introduction of several adjuncts.

BOERHAAVE’S SYNDROME: EARLY VS DELAYED TREATMENT

Lerut T.
Dept. of Thoracic Surgery, University Hospital Leuven, Belgium.

Case presentation and interactive discussion.
PANCREATIC FISTULA: TECHNICAL ASPECTS

Van Hee R.
Academic Surgical Center Stuivenberg, University of Antwerp, Belgium.

Pancreatic fistula occurs in circa 25% of patients after pancreatic resection (1). Various technical aspects during operative resection of either head or tail of the pancreas may influence fistula formation.

- The indication for operation, whether chronic pancreatitis or cancer, may play a role, due to the different consistency of the organ in both types of disease: in contrast to cancer, the firm parenchymal consistency in chronic inflammation enhances suture tightness and therefore diminishes fistula occurrence.
- The type of anastomosis between the pancreatic stump and the gastrointestinal tract has been studied thoroughly: no s.d. difference has been found in fistula frequency between gastric or intestinal drainage of the pancreatic tail (5).
- Duodenopancreatectomy can be performed with or without preserving the pylorus: this may influence the number of periduodenal lymph nodes excised (2) as well as the postoperative gastric emptying rate (3) but will not affect pancreatic fistula formation significantly (4).
- The location of the disease, especially of cancer, will evidently be of importance, and determine whether right or left resection will be necessary: Whipple procedures have a greater chance of leakage than distal pancreatectomy.
- In distal pancreatectomy salvage of the spleen has been debated since several years (7). As in pyloric saving Whipple procedures, sparing of the spleen should not induce a less thorough lymph node dissection of the perisplenic axis in cancer surgery. Spleen saving distal pancreatectomy did not statistically influence fistula formation (8). Therefore if compatible with the oncologic principles spleen saving should be encouraged.
- The laparoscopic approach of pancreatic resection has gained widespread interest in the last years. Laparoscopic Whipple operations seem to pertain to casuistic communications (8) and did medical, up till now not prove to statistically bring about medical, oncologic or financial benefits. Laparoscopic distal resections on the contrary improved significantly postoperative recovery, without increasing pancreatic fistula formation or other complications (9).
- These various technical aspects will be discussed in view of personally obtained results.

THE PHARMACOLOGICAL PROPHYLAXIS OF PANCREATIC COMPLICATIONS IN MAJOR PANCREATIC SURGERY

Gigot J.-F.
Saint-Luc University Hospital (UCL), Brussels, Belgium.

The postoperative complication rate after major pancreatic resection currently remains high (30–40%), and is mainly linked to the failure of the pancreatico-enteric anastomosis. The incidence of pancreatic fistula remains between 10 and 30% and is associated with a significant prolongation of postoperative hospital stay, and increased related-complications and costs. The most significant risk factors exposing to the occurrence of pancreatic fistula are the normal consistency of the pancreas, the absence of wirsung duct dilatation and the level of surgeon’s experience in major pancreatic resections.

The inhibition of pancreatic secretion by prophylactic peri-operative administration of somatostatine or analogues has been reported in several European (1-6) and American (7,8) prospective controlled clinical trials. Despite some differences in the design, in the definition of endpoints (especially the definition of pancreatic fistula), in the heterogeneous selection of underlying disease or of surgical procedures and some methodological criticisms concerning these trials, the multicenter European experience is in favor of the perioperative use of somatostatine or octreotide in the prevention of pancreatic fistula following major pancreatic surgery, especially in the high-risk group of patients with peripampillary malignancy. Moreover, a recent meta-analysis based on European trials emphasized the beneficial cost-effectiveness of this strategy (9). On the contrary, in the American trials performed in expert centers where the incidence of pancreatic fistula is low, the benefit of octreotide was not confirmed (7,8).

According to these results, the prophylactic use of somatostatine or analogues for preventing postoperative complications after major pancreatic resections appears to be a safe and cost-effective treatment strategy, especially in the high-risk group of patients suffering from peripampillary malignancy and when the surgeon case-load in major pancreatic resections is not important. However, a larger prospective randomised, blind, placebo-controlled multicenter trial is still required.

References:
GASTROINTESTINAL AND PANCREATIC BLEEDING AFTER PANCREATIC SURGERY: SURGICAL ASPECTS

Aerts R., Topal B.
Dept. of Abdominal Surgery, UZ Gasthuisberg, Leuven, Belgium.

Intraoperative hemorrhage during resection of the head of the pancreas is usually preventable with care being taken to define the vascular anatomy before and during the operation. Preoperative angiography provides a useful road map and may sometimes prevent catastrophic accidents due to preexisting thrombosis of major veins or to congenital arterial anomalies.

Immediate postoperative bleeding is usually intraperitoneal and due to incomplete hemostasis during the resection, especially due to small branches around the superior mesenteric vessels. Early gastrointestinal bleeding is rare and anastomotic. These bleedings are usually limited and can be prevented by meticulous surgical technique.

Delayed bleeding is mainly due to severe inflammation and autodigestion of peripancreatic tissues and major vessels secondary to the action of activated proteases from clinical or subclinical pancreatic leakage and drain usually in the gastrointestinal tract. Extensive skeletonisation of vessels during lymphadenectomy is a major risk factor. Prevention consists of meticulous technique in creating the pancreatojejunostomy and adequate drainage of the anastomotic site. When occurring these bleedings can be catastrophic and need prompt surgical reintervention. Usually the pancreatic remnant must be disconnected with external drainage, subtotal or even total pancreatectomy.

Minor bleeding and rare pseudoaneurysms can be treated with transarterial catheter embolisation. Marginal ulcers with gastrointestinal bleeding were frequent late complications after pancreateoduodenectomy but this is now rare.

PITFALLS OF VASCULAR RESECTION IN PANCREATECTOMIES

Bertrand Cl. (1), Glineur D. (2)
(1) Hôpital de Jolimont-Lobbes, Haine Saint-Paul, Belgium.
(2) Cliniques Universitaires Saint-Luc, UCL, Brussels, Belgium.

During pancreatectomy for cancer, vascular resection has been described from many years. Mainly, resections of the mesenterico-portal venous confluence have been realized, but too arterial resections of the superior mesenteric artery, the common hepatic artery, the celiac trunc.

The discussion will be focused on venous reconstruction, excluding arterial resection. In fact, these are still associated with an important mortality and poor survival.

A worthwhile procedure?

Tumor invasion of the portal vein and/or the superior mesenteric vein is classically described as a contraindication to resection of pancreatic cancer. However, many portal vein resections have been reported in the last decade.

- The mortality and morbidity rates remain in the same scale than for conventional resection, from 0 to 15% and 17 to 55% respectively.
- Japanese authors have described an augmentation of the resectability rate.
- However, this is the result, not only of the vascular resection, but too of extended dissection.
- For the more pessimists, it has no indication and no benefit. (Allema 1994)
- For Harrison (1997) and Leach (1998), survival rates are not different than after standard resections without vein resection (median survival of 13 months versus 17 and 20 months (versus 22). Fuhrman (1996) emphasised that tumors necessitating a portal resection are «not associated with higher rates of margin or lymph node positivity or other histopathologic factor associated with a poor prognosis». This operation is probably needed simply as a function of tumor location.
- A difference of survival has been shown in connection with the depth of infiltration of the vein. In case with invasion into the lumen, there is no survival of more than one year. In the cases resected «for necessity», at least 30% of the veins are uninvolved. They are resected based on a clinical impression. These cases could explain the survival benefit…
- With the aim of pre-operatively predict the benefit of vascular resection, Japanese authors have developed angiographic classifications based on the type of compression of the mesenterico-portal confluence (unilateral or bilateral narrowing, marked stenosis or obstruction with collateral veins) (Shikawa 1992, Nakao 1995) and on the length of compression (1.2 cm or less, or more than 1.2 cm) (Shikawa 1992).
**Per-operative pitfalls.**

The first problem is the venous mesenteric stasis which is in fact dependent of the occlusion time of the portal venous flow. This is assessed very differently by the different authors.

A quasi systematic use of an anti-thrombogenic catheter (Nakao 1990) has been described. An inflow occlusion is routinely used by others. The technique can be modulated following the expected occlusion time of the portal vein. However, there are no description of complications due to mesenteric venous stasis.

The second problem is the splenic and gastric venous stasis. This can lead to gastric or splenic hemorrhage. Total or near total gastrectomy can be necessary. Splenectomy has been used too.

In order to prevent gastric congestion, Tamura (1997) described 4 cases where the stump of the splenic vein could not be approximated to the portal or superior mesenteric vein. The splenic vein was shunted to the inferior mesenteric vein by preserving the confluence between the two vein or by making a spleno-inferior mesenteric vein anastomosis.

The third peroperative problem is the length of the resection. In most cases, an end-to-end anastomosis is realized. In some cases however, it is difficult to approximate the two veins. A large mobilization of the root of the mesentery can be done (Fortner 1977). In some cases, a graft is necessary. Many types of grafts have been used.

**Postoperative complications**

**Gastrointestinal bleeding**

Massive upper gastrointestinal bleeding have been mentioned (Cusack 1994), due to sinusial portal hypertension. He proposed whenever possible to preserve the splenic vein.

**Porto-mesenteric venous thrombosis**

This complication is not frequently cited. Early thrombosis remains a dramatic complication.

At late follow-up, Leach (1998) described 7 occluded reconstruction among 31 cases. 5 were asymptomatic, 2 died (7 and 16 months postoperatively).

**Hepatic ischemia**

There are no description of hepatic ischemia after venous resection with duodenopancreatectomy. This is in fact associated with arterial reconstruction. Nakao (1990) didn’t observe any correlation between hepatic function and the duration of occlusion, but he used a shunting technique.

**Conclusion**

The portal and mesenteric vein resection has thus actually certainly a place in the surgical techniques that we can use in the treatment of pancreatic cancer, in particular for the patients with only inflammatory adhesion to the portal vein. In these cases, a less aggressive attitude would preclude the benefit of an R0-resection. The exact place of the procedure remains however to be determined in the other cases. The authors relate too the own experience of there institution with these procedures.

**DELAYED GASTRIC EMPTING AFTER PANCREATICO-DUODENAL RESECTION**

Closset J., Gelin M.

Dept. of Digestive Surgery, Erasme Hospital, ULB, Brussels, Belgium.

With pylorus-preserving pancreaticoduodenectomy (PPPD) the goal is to reduce long-term morbidities as gastric dumping, marginal ulceration or bile-reflux gastritis. This has been assessed by retrospective studies. About the potential curative resection of PPPD versus Whipple procedure, retrospective studies have shown no difference in the long-term survival.

Compared with classical Whipple procedure, PPPD is affected by an equal postoperative morbidity but PPPD is known to induce delayed gastric emptying (DGE). It is difficult to evaluate the true incidence of DGE after PPPD, from 0 to 30 % in the literature, less than 5 % in our experience.

These factors play a role in DGE following PPPD:

- The length of the duodenal stump (preservation of the pacesetter).
- The meticulous preparation of the duodenal stump.
- The type of duodenojejunostomy.
- The infusion of somatostatin or analogues in the postoperative period.
- The primary disease, by modification of the anatomical or hormonal profile of the upper gastrointestinal tract.
- The duodenal resection.
- The lack of duodenal or pancreatic hormones.

Up to now, when DGE is observed the only way of treatment is to keep nasogastric suction, there is few significant data about the benefit of cisapride or other gastrointestinal prokinetic agents. Nevertheless early and low doses of erythromycin in the postoperative period could prevent the onset of DGE.

**References:**

COMPLICATIONS OF THE SURGICAL MANAGEMENT OF NECROTIZING PANCREATITIS AND PANCREATIC ABSCESS

Hesse U.J., De Waele J.W., de Hemptinne B.
Ghent University Hospital, Dept. of Surgery, Gent, Belgium.

The concept of CT guided fine needle biopsy has become the standard in the treatment of infected necrosis and abscesses in acute necrotising pancreatitis. At the same time an increasing percentage of patients with sterile necrosis are treated conservatively.

However, when surgical treatment for acute necrotising pancreatitis is required, surgical complications can occur such as recurrent intra-abdominal abscesses and necrosis, bowel perforation and pancreatic fistula as well as intra-abdominal haemorrhage.

Late complications are associated with the restoration of intestinal transit, late development of pseudocysts or abdominal wall hernias.

With the tight protocols of antibiotic treatment and conservative management of patients, the time of surgical intervention has been delayed and usually the patients are in better conditions then in the acute phase. In the own experience surgical complications were present in 71% of patients treated surgically and 64% of these patients required re-operation.

Most complications occurred 1 to 3 months after surgery and intra-abdominal abscesses and wound complications were most common. According to the literature these complications occur in 44% of the cases with pancreatic fistula in 29%, bleeding in 7%, burst of the abdomen in 4% and pseudocyst formation in 4%.

In particular the superinfection of necrosis with bacterial and fungal micro-organisms due to prolonged treatment with antibiotics appears to be worrisome, however, its significance on the clinical outcome remains controversial.

HOW WIDE IS WIDE: THE SURGICAL POINT OF VIEW

Bundred N.
Manchester, UK.

Locoregional recurrence (LO) is largely a function of residual tumour burden and margin status significantly influences therapeutic decisions to initiate additional surgical re-excision or a radiation boost to the tumour bed of the ipsilateral treated breast. It is recognised that complete pathological excision of the primary breast tumour is a critical part of breast conserving surgery to minimise rates of locoregional relapse in both invasive and in situ cancer. The optimal tumour margin can only be determined by careful pathological assessment of margin status according to standard protocols.

Several preoperative randomised studies have indicated that a margin greater than 1mm is sufficient to minimise LR, though most surgeons aim for a 1cm clearance. Larger clearance than 1cm impacts adversely on the cosmetic outcomes and is undesirable.

Recent evidence suggests that a young age (<40 years) or extensive intraductal component of a tumour on histology is associated with a higher risk of locoregional relapse. Wider margins are thus more important in patients who fall into these two categories. In in-situ cancer (DCIS) margin status greater than 1mm is associated with a low risk of relapse particularly in women with small good grade DCIS, although for higher grade and larger size tumour (>2cm) wider margins may be required. No surgical trials have thus far assessed the importance of margin status prospectively and most studies are non-randomised thus the quality of the evidence is limited. However, in summary the single most important factor affecting locoregional recurrence after breast conservation is the width of surgical margin and a width greater than 1mm appears sufficient. Extensive in situ/intraduct component is only relevant if the margins are involved.
Pre-operative mammographic evaluation and pathologic examination of surgical specimen are determinant for the selection of patients for breast conserving therapy (BCT). Surgical breast-conserving procedures (BCS) were simulated on a series of 135 mastectomy specimens from patients theoretically eligible for BCT to assess the performance of mammography in estimating tumor extension and the pathologic status of the surgical margin in predicting tumor residue after surgical resection. Mammography provides an acceptable estimate of the size of the index tumor, comparable with histological measurements in 75% of the cases. Nevertheless, mammography is less accurate in assessing tumor extension outside the index tumor with a mean difference of 12 mm between mammographic and pathologic measurements. The mammography review concludes 100 patients out of 135 (74%) could be candidate for conventional BCT with a cosmetically acceptable breast tissue defect. Tumor excision should include ideally 2 cm surgical margin (SM) of radiologically tumor-free tissue around the mammographically evaluated tumor area. Under these conditions, 27% of the breasts (27/100) still show residual tumor, 17% (17/100) with a high amount of tumor burden. The presence of tumor in the pathologic margin (PM) of the BCS specimen, defined as a 5 mm peripheral tissue rim, correctly predicts tumor residue in 74% of the cases (17/23). A re-excision of the surgical bed in case of positive PM seems inappropriate because tumor burden remains in 65% (15/23) of the re-excised breast. The predictable value of a positive PM for the presence of high amount of tumor residue in the breast raise a modest value of 48% (11/23). In 23 out of 100 patients, the involvement of the PM could implicate BCS conversion to mastectomy that would led to the potential overtreatment of 26% of the patients (6/23) without residual tumor in the breast. The quantitative evaluation of the tumor content of in the margin suggests mastectomy is only indicated if high amount of tumor is present in the PM (13 patients). The PM of the segmental resection was free of tumor for 77% of the patients (77/100), remaining eligible for BCT. Whole-organ study demonstrates the presence of high amount of residual tumor in the breast of 6% of the patients (6/100), that are the potential sources of local recurrence. The current study highlights the importance of multidisciplinary management of breast cancer necessitating high quality, state of the art mammography to select patients for BCT and directs surgical resection, wide tumor excision with 2 cm surgical margins and meticulous, qualitative and quantitative microscopic examination of the 5 mm large peripheral pathologic margin of the specimen.
SOFT TISSUE SARCOMA: PITFALLS AND COMPLICATIONS – HOW TO AVOID THEM?

Hoekstra H.J.
Dept. of Surgical Oncology, Groningen University Hospital, Groningen, The Netherlands.

Soft Tissue Sarcoma (STS) is a rare tumour. Half of the patients diagnosed with STS are over the age of 65 years. Although STS treatment protocols exist in almost all European countries, describing the whole diagnostic and treatment process, nevertheless, violation of these protocols occurs in half of the STS patients. Even in experienced centres there is a 20% protocol violation. The main reason for the protocol violation is the ‘unawareness of the potential malignant nature of a soft tissue mass’.

The varied clinical presentation of patients with soft tissue masses and the significant differences in treatment necessitates a thorough pre-therapeutic evaluation. The diagnostic process, as well as the treatment is a combined effort of several disciplines involved in the care of the STS patient. Optimisation of the preoperative work-up with radio diagnostic spiral CT, MR or MRA, or even PET provides the surgeon with optimal preoperative information about the extent of the disease and facilitates to determine the optimal place for the biopsy.

Although cytology may differentiate between benign and malignant, a true cut or incisional biopsy is essential in the preoperative histopathological diagnosis and subtyping with IHC and/or molecular markers. An inappropriate biopsy technique and histopathology of the soft tissue mass have an adverse impact on the disease outcome, e.g. increased rate of loco-regional failures.

Based on the extent of the primary or recurrent tumour, the final histopathology, and stage of the disease should the STS patient be discussed in a panel of specialists in the field of solid tumours and offered a (combined) treatment, surgery, radiation and/or chemotherapy. The STS patient is the ultimate cancer patient for which the multidisciplinary (centralized) treatment approach, in which beside the medical and radiation oncologist, all surgical disciplines participate, may avoid treatment complications and will provide the best treatment outcome.

The combined modality treatment improved the loco-regional treatment outcome of STS, but is complicated by increased long-term treatment related morbidity, often requiring extensive surgery. New promising treatment strategies are underway with molecular-targeted therapy such as the c-kit tyrosine kinase inhibitors for gastrointestinal stroma cell tumours and differentiation therapy for liposarcomas. The role of the surgeon in this kind of new treatment strategy is as yet undetermined, as well as the treatment related complications.

PITFALLS FOR THE SURGEON IN THE PATHOLOGY REPORTS

Marichal M.
Dept. of Pathology, AZ VUB, Brussels, Belgium.

A pitfall is defined as “a hidden or not easily recognized danger or difficulty”. In a pathology report, this can result in clinical errors. When analyzing the clinical errors resulting from a faulty or misunderstood pathology report, we can recognize three types of “pitfalls”. Pitfalls can be created by the clinician towards the pathologist (preanalytical), they can originate in the pathology laboratory (analytical), and finally they can emanate from the pathologist towards the clinician (postanalytical).

– The first type of pitfall can have several causes; the main deficiencies are found at the level of the specimen identification, the pathology request form and the handling of the tissue.
– In the analytical phase, errors are mainly the result of diagnostic errors by the pathologist and incomplete reporting. Diagnostic errors occur most frequently in difficult diagnostic fields, such as central nervous system tumours, breast lesions, and melanoma diagnosis. Incomplete reporting can be avoided by using checklist protocols.
– Postanalytical errors stem mostly from unfamiliarity of the clinician with the language and methods used in contemporary pathology. Surgeons may be unfamiliar with techniques such as resection margin investigation, immunohistochemical findings in (sentinel) lymph nodes, and results of molecular techniques.

The advent of the latter constitutes an immense step forward towards refined diagnostics; if we want to avoid pitfalls, however, these techniques should be paired with classical histopathology and immune-histochemistry. Finally, almost all pitfalls can be avoided if pathologists and clinicians communicate and do this with mutual respect for each other.
The surgical responsibilities in endocrine surgery are summarized in a surgical adaptation of the definition of ‘Evidence-based medicine by David Sackett. ‘It is the integration of best research evidence with our clinical expertise and surgical skills and patients values’

1. Best research evidence. Is defined as clinically relevant research, often from basic sciences of medicine, but especially from patient-centered clinical research into the efficacy and safety of therapeutic regimes. This relevant research evidence is used in the draw up of systematic reviews and guidelines. Systematic reviews can be found in an increasing number of electronic databases At present, the best of these is “Evidence-based Medicine Reviews” from Ovid technologies (www.ovid.com). Clinical practice guideline attempts to identify diagnostic and treatment strategies for common clinical problems, summarizing a vast quantity of medical knowledge into a readily usable format. Such an example is ‘The National Guideline Clearinghouse (NGC). It is a free web-based library resource for up-to-date evidence-based clinical practice guidelines (www.guideline.gov.) It is a centralized repository with more than 1750 clinical guideline. It contains 98 guidelines about endocrine diseases; 9 of thyroid diseases, 2 of parathyroid diseases and 2 of adrenal gland diseases. The most important one is perhaps the AACE/AAES medical/surgical guidelines for clinical practice management of thyroid carcinoma.

2. Clinical experience and surgical skills:
The outcome of surgical intervention, whether death or uncomplicated survival, or long-term morbidity, is not solely dependent on the abilities of the surgeon in isolation. The patient’s physiological status, the disease that requires surgical correction, the nature of the operation, and the preoperative and postoperative support services have a major effect on the ultimate outcome. Reviewing the literature in surgical outcome measurement we found two patient risk-adjusted outcome scoring systems from either side of the Atlantic Ocean: POSSUM and NSDIP. Both scoring systems will discussed because they are validated models. Both are drew up as quality improvement programs. It provides the surgeons and managers in the field with reliable information and consultative advice that will guide them in assessing and continually improving their local processes and structures of care.

3. Patients values: With patients values we mean the unique preferences each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

Conclusions
1. Systematic reviews and guidelines will play more and more an important role. Because that information is freely accessible for patients trough the internet, they will consult us armed with that information to discuss the indication of their operation.

2. Outcome risk-adjusted assessment in surgery is a fundamental pillar for the improvement of surgical care. The time has come to apply a recognized risk-adjusted scoring system and to adapt it with variables that are speciality specific. Perhaps our society can play a major role in the creation of a such a national database.

3. The patient has a right to be informed as adequately as possible in a understandable language. Patient brochures as proposed by our society will be published in the near future;
PEDIATRIC LIVER TRANSPLANTS WITHOUT CORTICOSTEROIDS


Corticosteroids have long been considered as a cornerstone of orthotopic liver transplantation (OLT) immunosuppression (IS). We hypothesized that steroid-free IS may not only be safe but also beneficial for graft acceptance, since steroids were shown to inhibit tolerance induction in animal models.

Patients and methods: Between February 2001 and January 2002, 18 pediatric OLT recipients (median age: 2.5 years; range: 0.6-13.0; living donor/post mortem grafts: 8/10) were included in a pilot protocol consisting of a steroid-free, tacrolimus (prograf) / basiliximab (simulect) IS regimen (group SfTB). Basiliximab was administered at the conventional intravenous dose of 10mg or 20mg (BW< or >35Kg), on days 0 and 4 post-OLT. These patients were retrospectively compared to 20 pediatric OLT recipients (median age: 1.5; range: 0.4-13.2; living donor/post mortem grafts: 13/7) transplanted between November 1999 and March 2001 under a conventional tacrolimus-steroid regimen (group ST).

Results: All patients were alive with their first graft on January 30, 2002, except for one child in group ST who died on day 159 from tumor recurrence after OLT for an epithelioid hemangioendothelioma. No adverse event related to basiliximab administration was encountered in group SfTB. The comparative incidence of acute rejection was 11% (2/18) in group SfTB versus 40% (8/20) in group ST (p=0.041, Fischer’s exact test), 9/10 episodes of biopsy-proven rejection occurring within 90 days post-OLT. No chronic rejection was reported so far in this series. Interestingly, two children in group SfTB were transplanted for cystic fibrosis without rejection and did not develop diabetes mellitus. The impact of steroid-free IS on arterial hypertension, lipidogram, infectious complications, and statural growth are currently being investigated in this pediatric population.

Conclusions: The preliminary results of this pilot study show a lower rejection incidence under steroid-free, tacrolimus- and basiliximab-based IS. The immunological mechanisms of this putative facilitation of graft acceptance through steroid avoidance are currently investigated. This strategy should be validated in a prospective randomized trial in pediatric OLT.

DIAGNOSTIC AND THERAPEUTIC PITFALLS IN PRIMARY HYPERPARATHYROIDISM

Van Hee R. Stuivenberg Hospital, Antwerp, Belgium.

Two pitfalls in the surgical treatment of primary hyperparathyroidism will be discussed: the "non discovered" parathyroid adenoma, and the unexpected parathyroid carcinoma.

1. Adequate localisation of a parathyroid tumoural mass is a prerequisite for selective resection of the parathyroid adenoma.
   The various visualising methods of a parathyroid mass by medical imaging techniques will be discussed and their accuracy rate determined.
   Combination of different imaging methods raises sensibility and specificity.
   Our own routine localisation methods in primary surgery consist of ultrasound, nuclear scintigraphy and CT-scan.
   Adjuvant techniques are MRI and PTH-venous sampling. The results of this approach will be discussed.

2. Parathyroid carcinoma is a rarely occurring disease. It is mostly a microscopic finding in patients with primary hyperparathyroidism. Some pathological and diagnostic features pertaining to parathyroid cancer may give some clues.
CONGENITAL AORTIC ARCH ANOMALIES

Astarci P., Bafort A.C., Verhelst R.

Aortic arch and vessels malformation are rare but very interesting by their clinical presentation and therapeutic options.

Embryological development is helpful to understand the morphology of the different types of malformation as well as the physiopathology and the symptoms. All anomalies are due to aberrant involution of the different aortic arches of the embryo.

Four types of anomalies are classically described:

1. Aberrant right subclavian artery with normal left aortic arch and retroesophageal right subclavian artery or "Arteria Lusoria"
2. Aberrant left subclavian artery with right aortic arch or "Neuhausser anomaly"
3. Isolated Left subclavian artery with right aortic arch

The symptoms of the aberrant right subclavian artery are rare in childhood but can be seen in the adult. Retro-esophageal position of the right subclavian artery can induce esophageal compression and dysphagia (dysphagia lusoria); furthermore aneurysmal dilatation of the artery have been described.

Double aortic arch is never seen in adult because esophago-tracheal compression developed frequently in the first years of life. It is the most frequent cause of aero-digestive compression in children.

Treatment of these anomalies is indicated in the presence of disabling symptoms or significant dilatation.
Different treatment strategies (surgical or endovascular) are available. We describe three cases of aortic arch anomalies and discuss the different treatment options.
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* Elections will take place during the General Assembly of RBSS on May 4th, 2002 at 12.15 hrs.
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| R.B.S.S.                  | L. PROOT | Chairman |
| R.B.S.S.                  | M.L. DRUART/L. MICHEL |
| R.B.S.S.                  | D. CLAEYS |
| B.S.C.R.S.                | W. VANEEERDEWEG |
| B.S.H.P.S.                | CL. BERTRAND |
| B.S.U.G.I.S.              | J.M. COLLARD |
| B.S.E.S.                  | L. MICHEL |
| B.S.B.S.                  | L. VEREECKEN |
| B.S.A.W.S.                |            |
| B.S.V.S.                  |            |
| B.G.E.S.                  |            |

**BW Gastro-Enterology**

| B.S.C.R.S.                | P. PATTYN |
| B.S.H.P.S.                | R. AERTS |
| B.S.U.G.I.S.              | J.M. COLLARD |
PRIZES

**KIEKENS**  
1999  
D. VAN RAEMDONCK

**JUNIOR**  
2001  
A. LOCHEGNIES  
2000  
K. THIJSSENS

**DUPREZ**  
2001  
M.A. RADERMECKER  
2000  
W. CEELEN

PREVIOUS BELGIAN SURGICAL WEEKS

**1st BSW**  
27-28-29th April 2000  
Theme: Minimally Invasive Surgery

**2nd BSW**  
3-4-5th May 2001  
Theme : Evidence Based Surgery

**3rd BSW**  
2-3-4th May 2002  
Theme : Surgical Pitfalls and Complications
Société Royale belge de Chirurgie
Avenue Circulaire 138A
1180 Bruxelles
Numéro d’identification: 1873/82

NOUVEAUX STATUTS

CHAPITRE Ier. - Dénomination, siège, objet, moyens, langues


Art. 2. Le siège de l’association est fixé à n’importe quel endroit en Belgique. Il est actuellement établi à Uccle, 1180 Bruxelles, avenue Circulaire 138A. Tenant compte de la procédure à suivre pour une modification de statuts, il ne peut être transféré que sur décision de l’assemblée générale statutaire.

Art. 3. L’association a pour objet d’encourager l’étude, le progrès, l’enseignement, la diffusion des sciences chirurgicales.

Moyens

Art. 4. Dans ce cadre, l’association :
1. Organise des réunions scientifiques et publie leurs comptes-rendus.
2. Promeut la formation scientifique du candidat spécialiste et la formation continue du chirurgien.
3. Crée des sections en vue de promouvoir les sous-spécialités chirurgicales.
5. Collabore avec d’autres organisations chirurgicales ou médicales, tant au niveau national qu’au niveau international.
6. Agit comme organe consultatif pour des tiers sur toute matière scientifique chirurgicale ayant des implications d’ordre éthique, économique et politique.
7. Édite une revue.
8. Crée un site internet chirurgical.
La Société Royale belge de Chirurgie ne poursuit aucun but lucratif.

Art. 5. Les langues véhiculaires de l’association sont le français, le néerlandais et l’anglais.
HOOFDSTUK II Leden en de voorwaarden tot toetreding en verlies van lidmaatschap

Art. 6. De leden van de vereniging worden onderscheiden in erelieden, titelvoerende leden, corresponderende leden, gewone leden, junior leden, honoriale leden en geaffilieerde leden.

Behoudens de erelieden, de honoriale leden en de geaffilieerde leden genieten alle leden van dezelfde rechten, in het bijzonder het stemrecht.

Art. 9. Verliest de hoedanigheid van lid:
1. Het lid dat zijn ontslag schriftelijk betekent bij de raad van beheer.
2. Het lid van de genees-, heel- en verloskunde die zijn heelkundige opleiding heeft beëindigd.
3. Het lid dat de bijdrage niet heeft betaald binnen de maand die volgt op de tweede herinnering die per aangetekende brief wordt toegestuurd.
4. Het lid dat weigert de bijdrage te betalen.
5. Het junior lid waarvan de heelkundige opleiding wordt stopgezet.

Art. 7. De voorwaarden tot toetreding:
1. Wordt als erelid toegelaten: elk lid dat zich verdienstelijk gemaakt heeft in de heelkundige wetenschappen en dat, als blijk van hulde, voorgesteld wordt door de raad van beheer.
2. Wordt als titelvoerend lid toegelaten: elk corresponderend lid dat regelmatig deel genomen heeft aan de wetenschappelijke activiteiten, zich onderscheiden heeft in de heelkundige wetenschappen en door de raad van beheer wordt voorgesteld.
3. Wordt als corresponderend lid toegelaten: elk gewoon lid dat, ofwel tijdens een zitting van het Genootschap een mededeling deed ofwel als eerste auteur een artikel gepubliceerd heeft in het tijdschrift van het Genootschap, op voorstel van de raad van beheer.
5. Wordt als juniorlid toegelaten: elke arts of dokter in genees-, heel- en verloskunde die een geneeskundige opleiding heeft beëindigd.
7. Wordt als geaffilieerd lid toegelaten: iedere geleerde, al dan niet chirurg, die door zijn werk bijgedragen heeft tot de vooruitgang van de heelkundige wetenschap.

CHAPITRE II - Membres, conditions d'affiliation et de démission

Art. 6. L'association est composée de membres d'honneur, membres titulaires, membres corres-pondants, membres ordinaires, membres juniors, membres honoraires et membres affiliés. A l' exception des membres affiliés, des membres d'honneur et des membres honoraires, tous les membres ont les mêmes droits, en particulier en ce qui concerne le droit de vote.

Art. 7. Les conditions d'affiliation sont les suivantes:
1. Peut être admis comme membre d'honneur: tout membre qui s'est distingué dans les sciences chirurgicales et qui est proposé, à titre d'hommage, par le conseil d'administration.
2. Peut être admis comme membre titulaire: tout membre correspondant qui a participé régulièrement aux activités scientifiques de l'association, qui s'est distingué dans les sciences chirurgicales et qui est proposé par le conseil d'administration.
3. Peut être admis comme membre correspondant: tout membre ordinaire pour autant qu'il ait, soit présenté un travail à une séance de la Société, soit publié comme premier auteur un article dans la revue de la Société et qui est proposé par le conseil d'administration ou parrainé par deux membres titulaires ou d'honneur.
4. Peut être admis comme membre ordinaire: tout docteur en médecine, chirurgie et accouchement, ayant terminé sa formation chirurgicale.
5. Peut être admis comme membre junior: tout docteur en médecine, chirurgie et accouchement, en cours de formation chirurgicale.
6. Peut être admis comme membre honoraire: tout membre de la Société royale belge de Chirurgie qui a cessé ses activités chirurgicales.
7. Peut être admis comme membre affilié: tout savant, chirurgien ou non, qui aura contribué au progrès des sciences chirurgicales par ses travaux.

Les candidatures doivent être adressées par écrit au conseil d'administration, au plus tard un mois avant la date de l'assemblée générale statutaire. L'admission des membres est décidée par l'assemblée générale statutaire, à la majorité des deux tiers des voix présentes ou représentées.

Art. 8. Le nombre de membres de l'association ne peut être inférieur à dix.

Art. 9. La qualité de membre se perd:
1. Par la démission notifiée par écrit au conseil d'administration.
2. Par l'exclusion prononcée par l'assemblée générale statutaire ou extraordinaire, au scrutin secret et à la majorité des deux tiers des voix présentes ou représentées.
3. Par défaut de paiement de la cotisation dans le mois qui suit le second rappel adressé par lettre recommandée.
4. Par refus de paiement de la cotisation.
5. Par abandon de la formation chirurgicale par un membre junior.
De raad van beheer moet het lid op de hoogte stellen van de opgelegde sanctie.

Art. 10. Het ontslagnemend of uitgesloten lid en de rechthebbenden van een ontslagnemend of uitgesloten lid, evenals van een overleden lid, kunnen geen enkel recht laten gelden op het maatschappelijk bezit van de vereniging en kunnen ook geen aanpraak maken op de terugbetaling van de gestorte bijdragen.

HOOFDSTUK III. De structuur van de vereniging


a) De secties krijgen als opdracht: de promotie van een bepaald domein van de heelkundige wetenschappen;

b) De comités helpen de raad van beheer bij de praktische realisatie van haar taken.

c) De commissies adviseren de raad van beheer en de algemene statutaire vergadering ten aanzien van de wetenschappelijke belangen die haar leden in de ruimste betekenis raken en die een ethische, economische of politieke dimensie hebben.

2. De raad van beheer kan samenwerkingsakkoorden afsluiten met andere chirurgische verenigingen.

3. De raad van beheer kan, mits motivering ten gronde, secties, comités en commissies ontbinden en samenwerkingsakkoorden met andere verenigingen stopzetten.


De secties
Art. 12. 1. Het Koninklijk Belgisch Genootschap voor Heelkunde kent secties zoals:

a) De sectie colo-rectale chirurgie.

b) De sectie endocrinologische chirurgie.

c) De sectie hepato-pancreatico-biliaire chirurgie.

d) De sectie oeso-gastro-duodenaal chirurgie.

e) De sectie senologie.

De lijst is niet beperkend.

2. De raad van beheer kan, indien zij dit noodzakelijk acht of indien ten minste 20 leden hiertoe een schriftelijke aanvraag (punt weg) indienen, nieuwe secties oprichten.

3. De voornaamste taak van de secties is het promoten van een kwalitatief hoogstaande chirurgie binnen het toegewezen deelgebied en met als specifieke taken:

a) De organisatie van wetenschappelijke bijeenkomsten.

b) Deelnemen aan de organisatie van de voortgezet vorming van de leden.

c) De organisatie van multicentrische klinische studies.

d) Het verzorgen van wetenschappelijke publicaties in het tijdschrift van het K.B.G.H.

e) Het helpen verzorgen van de chirurgische internetsite.

f) De samenwerking met gelijkstandige internationale verenigingen.

Le conseil d'administration doit informer le membre de la sanction prise.

Art. 10. Le membre démissionnaire ou exclu et les ayants droit d’un membre démissionnaire, exclu ou décédé, n’ont aucun droit à faire valoir sur l’avoir social de l’association et ne peuvent prétendre au remboursement des cotisations versées.

CHAPITRE III. - La structure de la société


Les sections ont pour rôle: la promotion d’un domaine particulier des sciences chirurgicales.

Les comités aident le conseil d’administration dans la réalisation pratique de ses tâches. Les commissions guident le conseil d’administration et l’assemblée générale dans les questions scientifiques ayant une dimension éthique, économique ou politique concernant les membres, au sens le plus large du terme.

2. Le conseil d’administration peut conclure des accords de partenariat avec d’autres associations actives dans le monde chirurgical.

3. Moyennant une motivation fondée, le conseil d’administration peut dissoudre les sections, les comités ou les commissions et annuler les accords de partenariat avec d’autres associations.

4. Les décisions mentionnées à l’article 11, § 1er-3, doivent être approuvées par l’assemblée générale avant d’entrer en vigueur.

Les sections
Art. 12. 1. La Société royale belge de Chirurgie inclut des sections comme:

a) La section de chirurgie colorectale.

b) La section de chirurgie endocrine.

c) La section de chirurgie hépato-bilio-pancréatique.

d) La section de chirurgie oeso-gastro-duodénale.

e) La section de sénologie.

Cette liste est non exhaustive.

2. Le conseil d’administration peut créer, si nécessaire ou à la demande écrite d’au moins 20 membres, de nouvelles sections.

3. La tâche principale des sections est de promouvoir une chirurgie de haut niveau. Dans le cadre de leur domaine spécifique, elles ont pour rôles :

a) L’organisation de réunions scientifiques.

b) La participation à la formation continue des membres.

c) L’organisation d’études cliniques multicentriques.

d) La publication d’articles scientifiques dans la revue de la Société.

e) L’aide à l’élaboration d’un site internet chirurgical.

f) La collaboration avec des sociétés internationales correspondantes.
1. Het Koninklijk Belgisch Genootschap voor Heelkunde bestaat ten minste uit volgende Comités:
   a) Een wetenschappelijk comité.
   b) Een redactiecomité.
   c) Een financieel comité.
   d) Een internet comité.
2. De raad van beheer kan, indien dit noodzakelijk blijkt, nieuwe comités oprichten.
3. De comités adviseren de raad van beheer ten aanzien van de wetenschappelijke belangen die haar leden in de ruimste betekenis raken en die een ethische, economische of politieke dimensie hebben.
4. De comités formuleren voorstellen, richtlijnen en normen die de kwaliteit van het chirurgisch handelen in de ruimste betekenis kunnen beïnvloeden.
5. De realisatie van deze voorstellen gebeurt in samenwerking met andere Belgische of Europese verenigingen actief op dit vlak.

De comités
2. De raad van beheer kan, indien dit noodzakelijk blijkt, nieuwe comités oprichten.
3. De commissies adviseren de raad van beheer ten aanzien van de wetenschappelijke belangen die haar leden in de ruimste betekenis raken en die een ethische, economische of politieke dimensie hebben.
4. De commissies formuleren voorstellen, richtlijnen en normen die de kwaliteit van het chirurgisch handelen in de ruimste betekenis kunnen beïnvloeden.
5. De realisatie van deze voorstellen gebeurt in samenwerking met andere Belgische of Europese verenigingen actief op dit vlak.

HOOFDSTUK IV. - Bijdragen


CHAPITRE IV. - Cotisations

Art. 15: Les membres titulaires, correspondants, juniors et ordinaires paient une cotisation annuelle, dont le montant est fixé annuellement et pour chaque catégorie de membres par l'assemblée générale statutaire. Le montant de la cotisation ne peut être supérieur à BEF 20 000 (EUR 500). La cotisation comprend un abonnement aux publications de l'association. Les membres d'honneur reçoivent la publication de l'association. Les membres d'honneur et les membres honoraires ne paient pas de cotisation et n'ont pas droit de vote.
CHAPITRE V. - Administration et fonctionnement

Art. 16. 1. L’association est administrée par un conseil d’administration composé d’une part de membres élus et révoqués par l’assemblée générale. Les candidatures doivent être adressées par écrit au conseil d’administration au moins un mois avant l’assemblée générale statutaire.

2. Au moins 50 % des membres du conseil d’administration, plus un, sont proposés par la Société Royale belge de Chirurgie. Les autres sont proposés par chacune des sociétés ayant conclu un accord de partenariat avec la S.R.B.C.

3. Les comités et les commissions aident le conseil d’administration quant à l’exécution de ses tâches (articles 12 et 13).

4. Des représentants de la Société Royale belge de Chirurgie, des sections et des sociétés ayant conclu un accord de partenariat siégent dans les comités. La composition de ces comités est définie par le conseil d’administration.

a) Le comité scientifique a pour rôle d’organiser les activités scientifiques de la Société Royale belge de Chirurgie. Il est présidé par les secrétaires des séances. Le président ainsi qu’un des secrétaires généraux de la Société Royale belge de Chirurgie en font également partie. Chaque section et chaque société ayant conclu un accord de partenariat avec la Société Royale belge de Chirurgie désignent un membre qui participe, à part entière, aux activités de ce comité. Le comité présente au conseil d’administration un rapport pour approbation.

b) Le comité de rédaction est responsable de la parution régulière des publications de la Société. La gestion financière est du ressort du conseil d’administration. Ce comité est présidé par les secrétaires de rédaction, qui en organisent les activités. Chaque section et chaque société ayant conclu un accord de partenariat avec la Société Royale belge de Chirurgie peuvent désigner un membre qui participe, à part entière aux activités de ce comité. Le comité présente pour approbation, un rapport au conseil d’administration et à l’assemblée générale statutaire.

c) Le comité financier, présidé par le trésorier de la S.R.B.C., a pour rôle de veiller à la gestion financière de la Société Royale belge de Chirurgie. Le président, ainsi qu’un des secrétaires généraux de la Société royale belge de Chirurgie, en font également partie. Chaque section et chaque société ayant conclu un accord de partenariat avec la Société Royale belge de Chirurgie désignent leur trésorier qui participe, à part entière, à ce comité. Le comité doit gérer les finances de la Société Royale belge de Chirurgie en bon père de famille. Le comité présente pour approbation un rapport au conseil d’administration et à l’assemblée générale statutaire.

5. In de commissies zetelen afgevaardigden van het K.B.G.H., de secties en van de verenigingen waarmede een samen-werkingsakkoord werd afgesloten.

Art. 17. De leden voor de raad van beheer worden tijdens de jaarlijkse statutaire algemene vergadering verkozen. De beheerders voor de volgende functies worden aan- gesteld door de algemene vergadering:
- de voorzitter, de eerste ondervoorzitter, de tweede ondervoorzitter, de secretaris- generaal, de adjunct secretaris-generaal, de twee secretarissen der zittingen, de twee redactiesecretarissen, de penningmeester, de andere beheerders.

5. Des représentants de la Société Royale belge de Chirurgie, des sections et des sociétés ayant conclu un accord de partenariat siègent dans les commissions. La composition de ces commissions est définie par le conseil d’administration.

Art. 18. De duur van het mandaat van een beheerder van het K.B.G.H. is vastgesteld op één jaar.
Het mandaat van de beheerders loopt ten einde:
a) als de termijn verlopen is op voorwaarde dat in de effectieve vervanging is voorzien,
b) in geval van voortijdig ontslag,
c) in geval van overlijden.

Indien een mandaat openvalt, vormen de overblijvende beheerders de raad van beheer met dezelfde bevoegdheden.

De ontslagnemende beheerders zijn maximaal zesmaal herkiesbaar voor dezelfde functie en de redactiesecretarissen maximaal tienmaal. Het mandaat van voorzitter en ondervoorzitter is beperkt tot één jaar. De voorzitter is slechts herkiesbaar in dezelfde of een andere beheersfunctie na drie jaar. De ondervoorzitters zijn onmiddellijk herkiesbaar in een andere functie.

Art. 19. De duur van het mandaat van een beheerder van het K.B.G.H. is vastgesteld op één jaar.
Het mandaat van de beheerders loopt ten einde:
- a) als de termijn verlopen is op voorwaarde dat in de effectieve vervanging is voorzien,
- b) in geval van voortijdig ontslag,
- c) in geval van overlijden.

Indien een mandaat openvalt, vormen de overblijvende beheerders de raad van beheer met dezelfde bevoegdheden.

De ontslagnemende beheerders zijn maximaal zesmaal herkiesbaar voor dezelfde functie en de redactiesecretarissen maximaal tienmaal. Het mandaat van voorzitter en ondervoorzitter is beperkt tot één jaar. De voorzitter is slechts herkiesbaar in dezelfde of een andere beheersfunctie na drie jaar. De ondervoorzitters zijn onmiddellijk herkiesbaar in een andere functie.

Art. 20. De raad van beheer bezit de meest uitgebreide machten om de vereniging te beheren. Alles wat niet door de wet of door de statuten is voorbehouden aan de algemene vergadering, valt onder haar bevoegdheid.

De rechtsvorderingen zowel als aanlegger of als verweerder worden, bij vervolging en benaastaarding van de voorzitter, ingesteld en verdedigd in naam van de vereniging door de raad van beheer. Buiten de overdracht van de machten nodig voor het ver- vullen van de functies waarvoor de beheerders zijn aangeduid, kan de raad van
beheer, onder zijn verantwoordelijkheid, het dagelijks beheer van de vereniging overdragen aan één of meerdere van zijn leden of aan een derde.

Art. 21. De andere beheersdaden dan deze van het dagelijkse beheer van de vereniging, worden onterechtend door de voorzitter of door twee beheerders die hun bevoegdheid niet mogelijk verwoorden ten aanzien van derden, tenzij de raad van beheer een bijzondere volmacht heeft verleend betreffende die dden.

Art. 22. De beheerders nemen, bij de uitvoering van hun functie, geen enkele persoonlijke verplichting op zich en zijn slechts verantwoordelijk voor de uitvoering van hun mandaat en de fouten begaan tijdens de uitvoering ervan. Het mandaat is onbezoldigd.

HOOFDSTUK VI. - Algemene vergadering

Art. 23. De algemene vergadering wordt samengesteld uit alle stemgerechtigde leden en voorgezet door de voorzitter van de raad van beheer of, in geval van ontsentenis, door één van de ondervoorzitters. Zij vormt het hoogste gezag van de vereniging. De bevoegdheden van de algemene vergadering omvatten:

1. De benoeming en de herroeping van de beheerders.
2. De toelating en de uitsluiting van leden.
3. De toelating en de uitsluiting van de geaffilieerde leden.
4. De benoeming van de ereleden.
5. Het oprichten en ontbinden van secties, commissies.
6. De bekrachtiging van de samenwerkingsakkoorden met andere verenigingen.
7. Het bepalen van het bedrag van de bijdragen.
8. De bevestiging van het bedrag van de bijdragen.

Art. 24. Er dient minstens één algemene vergadering per jaar te worden gehouden. De vereniging kan op ieder ogenblik, bij beslissing van de raad van beheer of op vraag van één vijfde van de stemgerechtigde leden tot een bijzondere algemene vergadering worden samengeroepen.

Art. 25. De leden worden bij een gewoon schrijven, dat ten minste acht dagen voor datum dient verstuurd te worden en onterechtend door de voorzitter in naam van de raad van beheer, tot de algemene vergadering uitgenodigd. De uitnodigingen maken melding van de dagorde. Elk voorstel dat onterechtend wordt door één twintigste van de stemgerechtigde leden, dient op de dagorde geplaatst te worden. Elk stemgerechtigd lid mag zich door een ander stemgerechtigd lid laten vertegenwoordigen. Elk aanwezig stemgerechtigd lid mag slechts houder zijn van één volmacht.

lesquelles sont désignés les administrateurs, le conseil peut, sous sa responsabilité, déléguer la gestion journalière de l'association à un de ses membres, ou à un tiers.

Art. 21. Les activités administratives autres que celles se rapportant à la gestion journalière de l’association doivent être signées par le président ou par deux administrateurs, qui n’ont pas à justifier leur compétence vis-à-vis de tiers, à moins que le conseil d’administration n’ait attribué une procuration bien précise pour ces activités.

Art. 22. Les administrateurs ne contractent, en raison de leur fonction, aucune obligation personnelle et ne sont responsables que de l’exécution de leur mandat et des fautes commises dans leur gestion. Le mandat des administrateurs est non rémunéré.

CHAPITRE VI. - Assemblée générale

Art. 23. L’assemblée générale est composée de tous les membres ayant droit de vote et est présidée par le Président du conseil d’administration ou, en cas d’empêchement, par l’un des vice-présidents. Elle en est le pouvoir souverain.

Les attributions de l’assemblée générale comportent :

1. La nomination et la révocation des administrateurs.
2. L’admission et l’exclusion des membres.
3. L’admission et l’exclusion de membres affiliés.
4. La nomination de membres d’honneur.
5. La création et la dissolution des sections, des comités et des commissions.
7. La fixation du montant des cotisations.
8. L’approbation des comptes et des budgets.


Art. 25. Les membres sont convoqués à l’assemblée générale par lettre ordinaire, adressée au moins huit jours avant la date de l’assemblée et signée par le président, au nom du conseil d’administration.

L’ordre du jour doit être joint aux convocations. Toute proposition signée par un vingtième des membres ayant droit de vote doit être portée à l’ordre du jour. Chaque membre ayant droit de vote peut se faire représenter par un autre membre ayant droit de vote. Chaque membre présent ayant droit de vote ne peut être porteur que d’une seule procuration.
1. De beslissingen worden genomen met eenvoudige meerderheid van de tegenwoordige of vertegenwoordigde stemmen, behalve in de gevallen anders beslist door de wet of de onderhavige statuten.
2. In geval van staking der stemmen is de stem van de voorzitter of van de beheerder die hem vervangt doorslaggevend.
3. De algemene vergadering kan slechts geldig beslissen over de punten op de dagorde vermeld.
4. Op aanvraag van één stemgerechtigd lid, worden de beslissingen van de vergadering bij geheime stemming genomen.

Art. 27. De beslissingen van de algemene vergadering worden ingeschreven in een register van de processen-verbaal, ondertekend door de voorzitter en de secretaris-generaal. Dit register wordt bewaard op de maatschappelijke zetel waar alle leden er inzage kunnen nemen.

Deze beslissingen verschijnen in de publicaties van de vereniging en kunnen eventueel per brief aan belanghebbende leden ter kennis worden gebracht.

HOOFDSTUK VII - Financiële middelen, jaarrekeningen, balansen

Art. 28. De financiële middelen van de vereniging bestaan uit bijdragen, schenkingen, subsidies, de opbrengst van de verkoop van de publicaties aan derden, de eventuele inschrijvingen voor wetenschappelijke vergaderingen, het jaarlijks congres en de publiciteit.

Art. 29. Het boekjaar vangt aan op 1 januari en eindigt op 31 december.

De rekeningen van het verlopen jaar en de begroting voor het komende jaar worden ter goedkeuring aan de algemene statutaire vergadering voorgelegd. De raad van beheer staat hiervoor in.

De goedkeuring van de rekeningen betekent een ontlasting van de beheerders van de vereniging.

HOOFDSTUK VIII - Wijzigingen van de statuten en ontbinding van de vereniging

Art. 30. De statuten kunnen slechts gewijzigd worden door een algemene vergadering, waarop twee derde van de stemgerechtigde leden of hun vertegenwoordigers aanwezig zijn.

Het voorwerp van de statutenwijzigingen moet speciaal vermeld worden op de uitnodigingen tot de algemene vergadering. Geen enkele wijziging kan aangenomen worden zonder een meerderheid van de twee derde van de stemmen.

Zo de wijziging betrekking heeft op artikel 3 van de statuten, kan ze slechts aangenomen worden bij unanimiteit.

Zo de twee derde van de stemgerechtigde leden op de eerste algemene vergadering niet aanwezig of vertegenwoordigd zijn, kan er een tweede algemene vergadering samengeroepen worden die een geldige beslissing kan nemen, welke ook het aantal stemgerechtigden in de vereniging waarradigt.
Art. 31. La dissolution de l’association ne peut être prononcée que par une assemblée générale réunissant les deux tiers des membres ayant droit de vote ou leurs représentants et à la majorité des deux tiers des voix.
Si les deux tiers des membres ayant droit de vote ne sont pas présents ou représentés à la première assemblée, il peut en être convoqué une seconde qui délibère quel que soit le nombre de membres présents ou représentés. Les décisions prises doivent être soumises à l’homologation du tribunal civil.
En cas de dissolution de l’association, l’assemblée générale désignera deux liquidateurs, déterminera leurs pouvoirs et indiquera l’affectation à donner à l’actif net de l’actif social.
Cette affectation devra obligatoirement être faite à une ou plusieurs associations poursuivant des buts similaires.

CHAPITRE IX. – Règlement d’ordre intérieur

Art. 32. Un règlement d’ordre intérieur peut être présenté par le conseil d’administration à l’assemblée générale.
Ce règlement et les modifications ultérieures qui y seraient apportées sont adoptées à la majorité simple des voix présentes ou représentées.

Art. 33. Tout ce qui n’est pas prévu explicitement aux présents statuts est réglé par la loi du 27 juin 1921 régissant les associations sans but lucratif.

(Signé) Prof. M. Meurisse, président S.R.B.C
(Signé) Dr. L. Proot, secrétaire général.
Royal Belgian Society of Surgery

4th Belgian Surgical Week
7 - 8 - 9 May 2003
FINAL SCIENTIFIC PROGRAM

Morning session (09h00 – 12h30)
Charmen: C. BERTRAND, G DELVAUX, M. GELIN.
* Physiopathology of liver metastases (LM)
  Dr MARIE (Gent)
* Radiological staging of liver metastases
  Dr. OP DE BEECK (Antwerpen)
* The role of nuclear medicine in the diagnosis,
  staging and treatment of liver metastases
  Dr LONNEUX and Prof. JAMAR (Brussels)
* Technical aspects of liver resection for liver
  metastases
  Prof. BISMUTH (Paris)
* Selection of patients for surgical treatment of
  colorectal liver metastases
  Prof. GIGOT (Brussels)
* Results of surgical resection of colorectal liver
  metastases
  Prof. AERTS (Leuven)

Lunch

Afternoon session (14h00-17h30)
Charmen: JF GIGOT, J WEERTS, D YSEBAERT.
* How to increase resectability in colorectal liver
  metastases ?
  Prof. ADAM (Paris)
* Selection of patients and results of surgical
  treatment of noncolorectal neuroendocrine LM
  Dr DETRY and Prof. HONORE (Liège)
* Selection of patients and results of treatment of
  neuroendocrine liver metastases
  Prof. KLEMPNAUER (Hannover)
* Adjuvant and neoadjuvant treatment of liver
  metastases
  Prof. VAN CUTSEM (Leuven)
* Local ablative treatment of liver metastases
  Dr DONCKIER and Prof. GELIN (Brussels)
* General Discussion (Experts panel)

REGISTRATION

This form must be send by mail or by fax to
the secretary of the PGC :

Doctor Claude BERTRAND
Hôpital de Jolimont
Rue Fener, 159
7100 HAINES-LE-PICE
Phone : 084/23.40.65 (Brigitte BAUDOUIN)
Fax : 064/23.36.81

Registration fee
for the scientific program : free of charge
for the lunch : 500 BEF

(on site registration for the lunch will not be possible)

Doctor ...........................................................................
  □ qualified surgeon
  □ trainee

Hospital .................................................................

City ..............................................................................
  □ will attend the PGC on september 28th, 2002
  □ will not attend the PGC on september 28th, 2002
  □ will attend the lunch during the PGC
  □ will not attend the lunch during the PGC

/payment by bank transfer onto bank account number :
  310 – 5045584 – 69 with the mention "HPB lunch PGC"

The official language of the PGC is English.
Simultaneous translation is not provided.
Bij patiënten die reeds goed onder controle zijn met Sandostatine en bij klinische symptomen waarbij de enzymen in de systeem tolerantie niet veranderen, kan de dosis van Sandostatine Long Acting Repeatable niet worden aangepast bij patiënten met levercirrose. Bij patiënten met pancreastumoren, peri-ampullaire tumoren en chronische pancreatitis, die een pancreatectomie of een pancreaschirurgie hebben ondergaan, moet de dosis van Sandostatine Long Acting Repeatable niet worden aangepast.

Contra-indicaties

- Geïsoleerde gevallen van leverstoornissen door toediening van Sandostatine werden gemeld en deden zich voor als acute hepatitis zonder cholestase. De waarden van de transaminasen normaliseerden zich na stopzetten van de toediening van Sandostatine.

- Ademhalingsvertraging na pancreaschirurgie moet de dosis van Sandostatine Long Acting Repeatable niet worden aangepast bij patiënten met levercirrose. Bij patiënten met pancreastumoren, peri-ampullaire tumoren en chronische pancreatitis, die een pancreatectomie of een pancreaschirurgie hebben ondergaan, moet de dosis van Sandostatine Long Acting Repeatable niet worden aangepast.