On about the 5th day she developed epigastric and left upper quadrant discomfort which first postoperative morning. She used a single daily bexecam tablet for analgesia for 7 days.

A 38 year old female patient presented with acute abdominal pain after passing a gallstone. The patient was not shocked, but was tender in the epigastrium. Her hepatocellular enzymes were normal and her hemoglobin had dropped to 11. She re-presented after passing a black stool on day 10 postop. The operation is challenging and has a steep learning curve, which is reflected in the operating times. The mean operating time was 189 minutes in the first 10 patients and 115 minutes in the next 2. After successful laparoscopic adrenalectomy patients had a median hospital stay of 2 days.

In summary, laparoscopic adrenalectomy is the new surgical gold standard for small and medium size benign adrenal lesions. Available data demonstrates advantages for laparoscopic surgery in terms of recovery and morbidity. Our local experience is maturing, and we aim to match the results of the leading international units.

The conversion rate to open surgery is 20-30% (compared with <5% for cholecystectomy). It takes longer and is more expensive. It benefits the patients by marginally decreasing the length of stay, analgesic requirements, wound infections and return to normal GI function. There is no difference in lymph node yield, tumour clearances or anastomotic leaks.

Enthusiasm for new techniques may lead to:
- Wide application before knowing real outcomes
- New complications
- Patients being unexpectedly hurt!

**CASE REPORT OF A NSAIDS INDUCED BLEEDING ULCER**

A 38 year old female patient presented with acute abdominal pain after passing a gallstone. She later underwent an uneventful laparoscopic cholecystectomy and was discharged on the first postoperative morning. She used a single daily bexecam tablet for analgesia for 7 days.

On the 5th day she developed epigastric and left upper quadrant discomfort which became progressively worse. She re-presented after passing a black stool on day 10 postop. She was not shocked, but was tender in the epigastrium. Her hepatic enzymes were normal and her hemoglobin had dropped to 11.

After fluid resuscitation, she underwent an emergency endoscopy, under conscious sedation, which identified an acute bleeding duodenal ulcer. She was transferred to another hospital where a bilateral laparoscopic adrenalectomy was performed in 20 patients over the last 3 years. The indications were phaeochromocytoma in 7, Cushing’s disease in 6 (2 of whom required a bilateral procedure), vagus nerve syn- dromes in 6, 2 incidentalomas and 1 isolated metastasis. In the first 10 cases, we converted in 5, but in only 1 in the last 12.

The operation is challenging and has a steep learning curve, which is reflected in the operating times. The mean operating time was 189 minutes in the first 10 patients and 115 minutes in the next 2. After successful laparoscopic adrenalectomy patients had a median hospital stay of 2 days.

In summary, laparoscopic adrenalectomy is the new surgical gold standard for small and medium size benign adrenal lesions. Available data demonstrates advantages for laparoscopic surgery in terms of recovery and morbidity. Our local experience is maturing, and we aim to match the results of the leading international units.
Laparoscopic anti-reflux surgery has proven to be one of the most popular laparoscopic procedures in general surgery. Published results are remarkably consistent, reporting a 90% cure of reflux at 10 years and a re-operation rate of about 5%. Serious morbidity is rare, though well described. Patient selection and surgeon experience remain the major determinants of outcome.

Since the open era, surgeons have tried various modifications of the wrap aimed at maximising the antireflux barrier while minimising post-operative dysphagia and wind and related problems. This study, undertaken by our practice, compares two year outcome for the “gold standard” 360° degree total (total Nissen) and 180° partial wrap.

It demonstrates different advantages for each operation, while confirming the overall excellent results that laparoscopic anti-reflux surgery can achieve.

The study, which was undertaken at the Kingsbury and Vincent Pallotti hospitals, is the first original research on laparoscopic anti-reflux surgery published from South Africa, and the first randomised double blind trial in any area of gastrointestinal surgery published from this country in more than 20 years.

Performed in a private practice setting with no extra tests or costs incurred for the funders or patients, it has demonstrated that clinical research can be carried out in this environment and need not be confined solely to the academic departments.

All patients remain under annual review on a long term database aimed at reporting outcome beyond 10 years.

**SOME OF THE TEAM AT JEFFERY AND PARTNERS**

**Diverticular Disease**

It is regarded as a “Western Society Disease” thought to be related to an over-refined, low fibre diet. The consistency of stools is such that high intraluminal pressures develop in the small bowel over time, over a period, force the mucosa through the muscle wall alongside perforating blood vessels forming the diverticula. It is rare before 30 years of age. 33% of the population over the age of 60 and 50% of those aged between 80 and 90 years have diverticulitis. Females are more often affected than males.

The increased pressure in the bowel may be associated with spasm. The circular muscle is thickened. Many of the diverticula contain a faecolith which may be retained indefinitely. This faecolith is probably the cause of inflammation.

The great majority have no symptoms. In those experiencing symptoms, such as pain or constipation, this may be related to the spasm or obstruction.

Diverticula (with or without an abscess) can vary in severity from a few days of being unwell with fever and constant pain in the left lower abdomen, to an emergency abdominal crisis requiring urgent operation. The disease may be insidiously progressive forming a chronic pelvic abscess, a picture of the colon or a fistula, discharging infection and gas into the bladder or vagina.

Chronic bleeding is relatively uncommon in diverticulosis, but occasionally acute haemorrhage may occur. Patients treated by endoscopic surgery usually have the diseased area resected with primary anastomosis and no covering stoma. It is very rare for a patient to need a permanent colostomy, although a patient with end-stage diverticula may elect not to have colostomy reversal. Bowel function and general health return to normal after surgery and recurrence of symptomatic diverticulitis or complications is rare.

**TAKING HOME MESSAGE**

Diverticular disease is a common, benign disease. It does not require antibiotics unless there are clear signs of inflammation. If the diagnosis is suspected clinically, the clinician is obliged to confirm it, and exclude a cancer. Symptoms, sometimes supplemented by barium enema prove helpful. On occasions, the diagnosis remains in doubt after both investigations, and can only be made by resection. Even so, at laparotomy and resection, the diagnosis of the diseased colon may preclude diagnosis until histological analysis.

For patients with asymptomatic or mild disease a high fibre diet, with or without a stool softener laxative is usually sufficient. When an attack of inflammation occurs a short course of antibiotics and a bland diet will usually resolve the symptoms in a few days. A severe attack will need treatment in hospital. If emergency operation is necessary it will usually require resection of the affected part of the colon and a temporary colostomy may be necessary. Patients treated by endoscopic surgery usually have the diseased area resected with primary anastomosis and no covering stoma. It is very rare for a patient to need a permanent colostomy, although a patient with end-stage diverticula may elect not to have colostomy reversal. Bowel function and general health return to normal after surgery and recurrence of symptomatic diverticulitis or complications is rare.

**Diverticular Disease**

**Sharon Wadecke** is our Nursing Team leader and joined us in 1998. She qualified in 1982 at GH and soon joined the GI Endoscopy Unit. She was appointed manager of the Endoscopy unit at Netcare City Park and later moved to Netcare Queens hospital as the Clinical Nurse Manager. Sharon has been highly regarded amongst her nursing and private practice as skilled in gastroenterology.

**Kathy Faul** joined us in 2000. She qualified with Sharon in 1982 and worked at Vincent Pallotti Hospital as a ward sister on the surgical ward. It was during her 14 years at this hospital that we recognised her commitment and excellence. For family reasons, she took a break from nursing hours and worked as the Clinical Nurse at Wynberg Pharmacy. When a Practice vacancy emerged, we snapped her up and has benefited from her common sense approach and commitment.

**Amanda Van der Venter** transferred to us from the endoscopy unit at Kingsbury Hospital where she had been for 4 years and fell in need of new challenge. She is from the Eastern Cape and, after completing her training in Uitenhage, moved to Cape Town in 1991. She worked for 8 years in Constantiaberg theatres before transferring to the new endoscopy unit at Kingsbury.

**Carin Badenhorst** After matriculating in 1983, she trained at Tygerberg, before joining the Medicalic group. She worked for them in theatre and endoscopy for 17 years, completing a 1 year Advanced Nursing course through RAU and, later, achieved the highest mark in the Theatre Technique course. After 2 years as a PA and scrub sister for a private surgeon in Panorama, she joined us earlier this year.

We are proud of the standard and commitment of our nursing team.

**Colonoscopy** is the most important diagnostic test. This procedure has been shown to be safe, effective and cost effective. We expect those to be increasing interest in colonoscopic testing in government and private practice as skills develop in this challenging technique.

**The management of large bowel obstruction due to colon cancer is always challenging. These patients are often old, unwell, dehydrated, and commonly have metastatic disease. In addition, operating on a dilated colon is technically difficult and many of these patients will require a colostomy, with no extra tests or costs incurred for the funders or patients, it has demonstrated that clinical research can be carried out in this environment and need not be confined solely to the academic departments.**

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**Nissen 360° wrap**

**Nissen 180° wrap**

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**Introduction of the wind over that guide wire**

Colonic stenting is a new application to decompress the bowel in the emergency setting without surgery. A fistula often effective palliation in patients who have incurable disease. In addition, operating on a dilated colon is technically difficult and many of these patients will require a colostomy, with no extra tests or costs incurred for the funders or patients, it has demonstrated that clinical research can be carried out in this environment and need not be confined solely to the academic departments.

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