(4.4%) complications occured; in one patient as mechanical obstruction, in two patients as appendiceal stump abscesses, and in one patient as subhepatic abscess. Suction drainage was applied in 3 patients(3.3%). The rate of negative laparoscopic exploration was 11,1%. Only two (2.2%) conversion to an open procedure was practiced; nonvisualization because of regional inflamation 1(1.1%) and regionalinflamation 1(1.1%).

Conclusion: The laparoscopic treatment of acute apendicitis an a safe method, which can be used in suited patients with low morbidity and mortality

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Laparoscopic management of complication of meckel's diverticulum

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Abstract: The laparoscopic approach became recently valid for many surgical emergencies such peritonitis and bowel obstruction from many reasons. We describe our experience with two patients which explorative laparoscopyled to the diagnosis and treatment of complicated Meckel's diverticulum. One of them with intestinal obstruction and the second with massive gastrointestinal bleeding. Although 99mTc pertechnetate scintigraphy is a sensitive and specific test for Meckel's diverticulum, in adults, the scan contributes little to surgical decision making and often did not change the need for surgical intervention. We think explorative laparoscopy is safe and efficient tool for diagnosis and treatment of complicated Meckel' sdiverticulum and the practice of this procedure should be recommended.

POSTER ABSTRACTS

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The relation between histological finding of the gallbladder and surgical difficulty in Mirizzi's syndrome

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BACKGROUND: Mirizzi Syndrome is a rare biliary pathology caused by compression of the stone in the cystic duct or neck of the gallbladder. It is characterized by narrowing of the common hepatic duct due to mechanical compression or inflammation. This study aimed to assess the degree of histological inflammation of the resected gallbladder in patients with Mirizzi's Syndrom and its effect on surgical difficulties.

METHODS: Between January 1992 and December 2002, a total of 11(8 females and 3 males) patients with Mirizzi's Syndrom who were treated at the 1st Department of Surgery of SSK Vakif Gureba Training Hospital, were retrospectively evaluated. Histological evaluation was classified as acute and chronic findings. Each histological finding was further classified into four stages by degree of inflammation(none, slight, moderate, severe). The difficulties related to the surgical procedure were graded in 5 categories.(the time required for the dissection of adhesion, anatomical variation, gallbladder wall thickness etc.)

RESULTS: The mean age was 57.7 years. In 5 of the patients laparoscopic cholecystectomy was attempted (2 of them completed laparoscopically), while open cholecsytectomy was performed in 6. Where as Mirizzi type II was diagnosed in 7 of the cases, 4 of them had Mirizzi type I. Histological evaluation revealed acute inflammation in 3 cases, chronic inflammation in 2 cases and both acute and chronic inflamatory finding in 6 cases. Degree of inflammation were mild in 1, moderate in 5 and severe in 3 cases. While Mirizzi type I cases exhibited acute inflammation predominantly, the Mirizzi type II cases revealed chronic inflammation predominantly. Chronic inflammation was more related to the difficulties during the procedure.

CONCLUSIONS: We found out that histological degree of inflammation was high in both types of Mirizzi Syndrome. While acute inflammation was remarcable in Mirizzi type I, chronic inflammation was predominant Mirizzi type II. Chronic inflammation was related to difficult surgery in cases with Mirizzi's Syndrome.

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Biloma after laparoscopic cholecystectomy

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Background: The aim of this study was to evaluate diagnosis and treatment of biliomas caused because of bile tract injuries in spite of increasing surgical experience and rutinly useage of laparoscopic cholesistectomy.

Material and Method: Laparoscopic Cholesistectomies which have been performed between January 2000 to January 2002 in our clinic were included to the study.Cases were evaluated according to the way and the location of the injury, metods used in diagnosis and treatment and mortality and morbidity.

Results: Size and the location of the injury were diagnosed by computered thomography and ultrasonography. ERCP, sphinterotomy and percutanouos drainage were performed to all patients. In 3 cases bile leakage has ceased in 7 days after drainage. Hepaticojejunostomy was performed to a case who have developed Bismuth type III stenosis. We had no mortality.

Conclution: ERCP is the gold standart for the diagnosis of biliomas and first of all biliomas have to be drainaged percutaneously. Surgical treathment has to be considered for the severe bile tract injuries which could not treated with sphincterotomy and biliary stent insertion.

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What is the diagnostic value of ultrasonography before laparoscopic cholecystectomy

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Laparoscopic cholecystectomy (LC) is the standart procedure for the treatment of symptomatic gallbladder stones. However of all LC, 1-13% require conversion to an open cholecystectomy.

Aim: It would be helpfull to establish criteria that could asses the risk for conversion, preoperatively. We aimed in this study to determine the risk for conversion by using ultrasonography.

Methods: In this study 7 parameters were evaluated in each of 100 patients by ultrasonographic examination in order to predict the surgical complication, difficulties and the probability of converting to open surgery. This parameters were gallbladder size and volume, number, size and mobility of calculi, wall thickness and ejection fraction (EF). Also the operative findings, including adhesions, difficulty in dissecting callot triangle and gallbladder bed, bleeding and operation time were collected and compared with the preoperative US findings. The results were analysed statistically.

Results: In 40 patients preoperative findings revealed that the operation could be difficult. The laparoscopic procedure was converted in 2 patients to open and in 36 patient the operation was difficult according our operative assesment.

Conclusion: We found out that EF, wall thickness and gallbladder size can be used as predictive ultrasonographic findings in preoperative assesment.

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The effect of histological inflammation degree on gallbladder perforation during laparoscopic cholecystectomy

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Background: Laparoscopic cholecystectomy (LC) is the gold standart technique for the treatment of symptomatic gallstones. Intraoperative gallbladder perforation is the possible and common complication of this technique. The aim of this study was to identify the effects of inflammation degree on gallbladder perforation during LC.

Methods: Between July 1997 and December 2002, 481 patients underwent LC for symptomatic gallstone disease at the 1st Department of Surgery of Vakif Gureba Training Hospital. During this period, 28 (%5) patients required conversion to open surgery and excluded from the study. Data was collected retrospectively . Patients with and without gallbladder perforation were compared in terms of sex, age, acute inflammation , chronic inflammation, anatomic difficulty, experience of the surgeon, omental and organ adhesions to the gallbladder.

Results: Intraoperative gallbladder perforation occurred in 69 cases (% 14,34). Although no differences were found for age, sex and chronic inflammation, there were significant difference between acute inflammation ($p< 0.05$), anatomical difficulty ($p<0.001$), experience of surgeon ($p<0.001$) and omental ($p<0.001$) and organ adhesions ($p<0.001$).

Conclusions: Gallbladder perforation is common complication of the laparoscopic cholecystectomy. Acute inflammation, experience of the surgeon, anatomical difficulty, adhesions of the omentum and others organs to the gallbladder play an important role in gallbladder perforation during laparoscopic cholecystectomy.

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Comparative study of return to work after laparoscopic or open cholecystectomy

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Aims: The goal of this comparative study is to establish whether there is discrepancy between the time needed to regain the ability to work among patients treated with laparoscopic cholecystectomy (LC) method and the patients treated with open cholecystectomy respectively.

Methods: In this prospective study we analised the delay in return to work following LC and OC among 100 patients who underwent these surgical procedures at Surgical Clinic, Clinical Center Nis during 2002. All patients involved in the study were employed and diagnosed with chronic calculous cholecystitis without intraoperative complications. They were divided into two equal groups, 50 patients each, similar in respect with sex, age and physical effort at work. General practice specialists who supervised their recovery after hospital discharge conducted semistructured interviews with the patients. The patients were interviewed twice, 4 and 6 weeks after the procedure.

Results: The median age of the patients was 45 (raging from 25-63). The median rate of delay in return to work among patients treated with LC was 14,3 days (5-21) and 27,1 (12-37) among patients treated with OC. The first group also had significantly shorter period of hospitalisation.

Conclusion: The LC represents golden standard in the treatment of gallstone disease with significantly shorter delay in return to work.

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Laparoscopic cholecystostomy in acute cholecystitis in elderly patients

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INTRODUCTION: Cholecystitis, in a disease of chemical or microbial inflamation of the gallblader which has a high mortality can cause acute peritonitis by the delay in the treatment. Cystic duct obstruction, ischemia and infection are the tactors which have role in etiopathogenesis: Early laparoscopic intervention is becoming a prefered approach in the treatment

MATERIALS AND METODS: Seven cases over 65 years old were included to our study which were subjected to operation between. January 1999-July 2003 in our clinic All the cases were accepted to operation to perform laparoscopic cholecystectomy. Operation Technique. Abdominal cavity was explorated by the insertion of the trocars in optimal positions. Findings which suggest acute cholecystitis were the swelling of gallblader, pallblader bed. porta hepatis mid Callot, of gallblader wall and hidrops of the gallblader were present in all cases, We concluded to perform cholecystoctomy to the patients of which cholecystectomy was impossited laparoscopically nor conventionally Gallblader was discharged with an insertion of a Veres needle Foley catheder of" 16F was inserted. from ft trocar entrance to the cross-like incision on the fundus of the gallblader and ıt's baloon was filled wich saline solution.

RESULTS: Three of the cases (%42,8) were men and 4 of the cases (%57.2) were women and the mean age was 66, 5 years old The catheter used lor cholecystostomy was KEPT in for 2 months. Two months later, laparoscopic cholecystectomy was performed to S of the cases (%71) and conventional cholecystectomy was performed to 2 of the cases (%29), Mean hospital stay was 6 daya and there was no mortality

CONCLUSION: Mortality and morbidity of acute cholecystitis in elderly patients due to the operation is high, In the treatment of acute Cholecystitis there was no significant difference between early and delayed surgical intervention compared with mortality and postoperative complications. Curently early laparoscopic surgical treatment is the most popular approach, When cholecystectomy is techniqually impossible, laparoscopic cholecystectomy is the choice lor surgical treatment Cholecystostomy decision must be given before the dissection is progressed Laparoscopic cholecystectomy is a minimal invasive procedure and enables a possibility for laparoscopic cholecystectomy procedure which will be performed subsequently.

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Safety of laparoscopic cholecystectomy on a teaching service: do beginners adversely affect outcome of the operation?

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Aim: The aim of this study is to evaluate the safety and outcome of elective LC as a supervised teaching procedure.

Materials: One hundred and sixty six consecutive patients who had elective LC between May 2000 and May 2003 for symptomatic cholelithiasis at a single teaching clinic were recorded retrospectively. LC were allocated to three groups: Group 1(n=42) were done by supervised beginners (who had done fewer than 11 LC), Group 2(n=69) by supervisewd trainees who had a little experience (they had done more thjan 10 but fewer than 29) and the Group 3(n=55) who were experienced surgeon (they had done more than 30).The groups were evaluted according to demographics of the patient, duration of the operation, conversion rate to open technique, minor (minor blood loss, intraabdominal loss of gall stone, superficial damage to liver tissue) and major (major bleeding, bile duct injury, biliary leakage, intestinal injury, vascular injury) intraopewrative complications, reopera-

tion, port-site complication(wound infection, incisional hernia), systemic complication(cardiac, pulmonary, deep venous thrombosis), postoperative hospital stay and mortality.

Results: The minor intraoperative rates wetre 20/42, 19/69, 11/55 respectively.It was statistically significant when group 3 were computed with others. There were no significant difference between three groups regarding major complications .The conversion rates were 3/42, 2/69, 1/55.The etiology of convertion to open surgery was difficulty of Callot dissection due to acute cholecytitis in two cases in Group 2 and 1 case in Group 3, and injury to cystic artery in 2 cases and hemorrhage due to liver injury in 1 case in Group 1. One patient was reoperated because of biliary fistula due to biliary tract injury in Group 1. Also one patient with biliary fistula was managed by ERCP in Group 2. Median length of operation were 88 (44-155), 57(25-101) and 49(21-99) minutes and hospital stay were 3(1-11), 2(1-5) and 1,2(1-3) days. There was no mortality in all groups.

Conclusion: LC is a safe and an useful procedure for introducing and educating supervised inexperienced surgeons who do not adversely affect operative outcome.

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Laparoscopic management of lymphocele after renal transplantation

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Lymphocele occur following % 0, 6 - 18, and 1 of renal transplantation. Most of lymphoceles develop within the first year of transplantation. Although they are asymptomatic, they can cause an increase in creatinine levels, decreased urine output resulting from compression of the kidney or ureter, a palpable mass or abdominal pain or edema and leg pain from compression of the iliac vein. Once a lypmhocele has become symptomatic

this condition has to be treated. Therapeutic options are percutaneous drainage, needle aspiration with sclerosing therapy, or internal surgical drainage by conventional or laparoscopic approach. Laparascopic drainage has every advantage of laparascopic surgery compared to open drainage with additional lower recuurence rate. We report two cases of post-transplant lymphocele treated with laparoscopic internal peritoneal drainage among 300 cases between August 2000 and August 2003.

Case I: Patient was 57 years old, female. She was admitted with edema of the ipsilateral leg, 28 days after transplantation. Serum creatinine was increased from baseline value of 1, 6 to 2, 0 mg/dl. On ultrasonographic examination lymphocele was observed measuring 63x74 mm. percutaneous drainage was applied. One week later it recurred. Then laparoscopic internal peritoneal drainage was applied. After that procedure creatinine level was decreased. No recurrence was observed after 6 months follow up.

Case II: Patient was 33 years old, male. At first month follow up his serum creatinine level was detected as elevated from 1,8 to 2,84mg/dl. Lymphocele was found at ultrasonographic examination measuring 77x100 mm. After recurrence following percutaneous drainage, laparoscopic internal peritoneal drainage was applied. There was no recurrence after 6 months follow up.

Conclusion: The laparoscopic approach has become widely accepted for the treatment of lymphoceles following kidney transplantation because of shortened hospitalization, minimal morbidity, cosmetic results and low recurrence rate. Laparoscopic internal peritoneal drainage may be considered a safe and effective procedure of management symptomatic lymphoceles. According to our knowledge, those are the first cases performed laparosopically in our country. I will be registered in couple of days and forward the registration form to you immediately

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Fatal complication of laparoscopic cholecystectomy: mesenteric ischemia

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AIMS: Laparoscopic cholecystectomy has become the standard treatment for symptomatic cholecystolithiasis. Intestinal ischemia cases after laparoscopic cholecystectomy were rarely reported. We raport a case of fatal mesenteric ischemia following laparoscopic cholecystectomy.

CASE: A 70 year-old man was admitted with a right upper abdominal pain has been occuring sometimes for two years. Cholecystolithiasis was diagnosed with investigations. He had no other disease. Laparoscopic cholecystectomy was performed in 50 minutes under 12 mmHg pressure without any problem. He had some moderate abdominal pain postoperatively first day. The pain increased in postoperatively second day and rebound tenderness in lower abdomen and leucocytosis (24000/mm^3) developed and intestinal sounds were hypoactive. General condition of the patient was impaired and our decision was laparotomy in the same day. In abdominal exploration, it has been observed intestinal necrosis from 20 cm distal of Treitz to the beginning of sigmoid colon. Additionally, there were many calcified atherom plaques in abdominal aorta and major branches. Intestinal resection and end-to-end anatomosis was performed. The patient was lost after 36 hours of that second operation.

CONCLUSION: Increasing of the abdominal pressure with pneumoperitoneum can cause a decreasing of the blood flow in splanchnic area. Especially in elderly with atherosclerosis and/or limited cardiac reserve, this decreasing may not be tolerated. As a result, laparoscopic procedures with a CO2 pneumoperitoneum may be performed at a pressure of 10 mm Hg or lower to avoid splanchnic microcirculatory disturbances and mesenteric ischemia should be considered in the differential diagnosis of patients developing nonspecific abdominal symptoms after laparoscopic procedures.

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Laparoscopic practices in colorectal malignancies

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Aims: Laparoscopic procedures for colorectal malignancies have been considered with increasing surgical experience of laparoscopy and advancements in technology. The aim of this study was to examine the results of a single institution experience with laparoscopic resection for colorectal malignancies.

Patients: Between March 2002-July 2003, 10 patients with colorectal malignancy had been operated laparoscopically in our institution. Seven (70%) of the cases were male, three (30%) were female patients. Mean age was 61 (48-74).

Results: Procedures performed were: low anterior resection (four), right colectomy (two), left colectomy (one), sigmoidectomy (one), sigmoid colostomy (one). One case was converted to celiotomy bearing a rectal tumor and APR was done. There were no deaths. The mean duration of operation was 155 (60-180) minutes. Postoperative complication developed in four cases; lengthened paralytic ileus (one), bleeding occured at the trocar site (one) retraction of the colostomy (one) and anastomotic leakage associated with urinary fistula (one). The mean length of hospital stay was 7.4 (2-14) days. The mean follow-up was 5.7 (1-17) months.

Conclusions: Although laparoscopic resections in colorectal malignancies are performed in many centers at present, the results are still subject to debate. Despite the prolonged operative time, laparoscopic procedures for these patients provide faster return of gastro-intestinal functions and early recovery. The increase of experience and the results of randomized studies would be of help.

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Laparoscopic repair of recurrent inguinal hernias

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Aims: Reccurent inguinal hernia surgery is usually difficult to perform due to fibrosis and non-intact anatomic structures. Therefore, laparoscopic interventions seem to be rational in those cases and are increasingly used. Herein we present our experince in recurrent inguinal hernia treatment by laparoscopic approach.

Methods: We retrospectively evaluated the patients who underwent laparoscopic recurrent inguinal hernia repair in Istanbul University Cerrahpaşa Medical School, Department of General Surgery.

Results: Thirty-two patients underwent total extraperitoneal repair (TEPP) with polypropylene prosthetic mesh due to recurrent inguinal hernias. There were twenty-nine (90.6%) unilateral and three (9.4%) bilateral recurrences. In two patients (6.25%) the procedure was converted to open repair due to technical difficulties. The mean operation time was 72 min (range, 65-86 min.). Intraoperative complications have taken place in seven (21.8%) patients (pneumoperitoneum in five and inferior epigastric vessels injury in two) and the trouble could have been dealed laparoscopically in each case. There were minor postoperative complications in seven (21.8%) patients including wound infection, seroma, tissue reaction and hematoma. Mean hospital stay was 2.1 (range, 1-10 days) days. Mean follow-up was 34.4 (14– 58) months. Recurrence was observed in one patient(3.1%).

Conclusions: Laparoscopic repair of recurrent hernia which utilizes technically healtier tissues, has better long-term results. This approach seems to be a reasonable alternative to open technique.

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Trocar site hernias after laparoscopic cholecystectomy

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AIMS: Complications of laparoscopic surgery attracts attention as advances in laporoscopic techniques leads to its widespread use in surgery. In this study we aimed to determine the risk factors causing trocar site hernias, which is one of the complications of laparoscopic surgery

METHODS: Between December 1999 and March 2003, 115 patients has undergone laparoscopic cholecystectomy, at Depatment of 3rd General Surgery, Şişli Etfal Training and Research Hospital. Two (%1.7) of these patients and 2 patients who had been referred from an other hospital, have attended to our clinic with postoperative trocar site hernias. The length of postoperative period until the hernia occured, location of the hernias, wound infection and whether the insicion had been sutured at the operation or not have been evaluated for all patients.

RESULTS: All the patients who have been operated for trocar site hernias were female. The mean age was 58 (55-90) years. The hernias have occured between the 2nd postoperative day and 48 months, and they were all located belove the umblicus where the 10 mm port had been placed. Non of the port sites had been sutured at the operations. One patient had developed wound infection at the port site. Two patients has undergone primary repair and the other two hernias were repaired with prolene mesh.

CONCLUSION: The most important risk factors affecting trocar site hernias are, the diameter of the trocar, not suturing the fascia defects larger than 10 mm, insufficient aproximation of the fascia and infection.

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Laparoscopic treatment of ventral hernias

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Aims: Our objective was to evaluate our preliminary results of laparoscopic ventral hernia repair.

Methods: We asessed the records of the patients who underwent laparoscopic ventral hernia repair in PTT Training and Research Hospital, Department of General Surgery.

Results: Between March and May, 2003, four patients underwent laparoscopic ventral hernia repair with polypropylene prosthetic mesh. All of the patients were female and the mean age was 54.5 (range, 44-65). The etiologies were incisional hernia and umblilcal hernias in two patients each. Moreover, there were concomitant cholelithiasis in two patients. We performed laparoscopic repair in every case successfully. In two patients, an additional laparoscopic cholecystectomy was added to the procedure. Four trocars were used in three operation whereas five trocars in one. The mean operation time was 130 minutes (range, 90-160 minutes) and mean hospital stay was three days (range, 2-4 days). There was no early postoperative complication. For a mean follow-up time of 5.7 months (range, 5-7 months) no hernia recurrence was observed.

Conclusions: Laparoscopic repair of ventral hernia surgery seems to be quite practical to perform. This technique provides further comfort while laparoscopic management of a concomitant disease, such as cholelithiasis, is considered.

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Duration of hospitalization in laparoscopic surgery: 6-24 hours

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Laparoscopic surgery has a lot of advantages. One of them is short stay in hospital. From January 2000 to September 2003, 99 consecutive laparoscopic surgical procedures have been performed by Öğünç. Demographic features of patients are shown in Table I. There was no comorbidity in all patients.

There was no morbidity and mortality in the postoperative period. There was no requirement of admission to the hospital. The results obtained from this personal series suggest that patients who have been performed laparoscopic surgery could safely be discharged on the first day (6-24 hours) following the operation.

Table 1. Demographic features of patients.

Laparoscopic procedure	Number of patients	Gender F/M	Mean age	Duration of hospitalization
Gastric banding	7	5/2	36.7	1 day
Splenectomy	2	1/1	22.0	1 day
Partial fundoplication	2	1/1	43.5	1 day
CAPD cath. placement	26	18/8	48.4	1 day
Diagnostic laparoscopy	5	3/2	39.4	1 day
Nephrectomy	1	1	72	15 hours
Incisional hernioplasty	1	1	41	14 hours
Cholecystectomy	39	28/11	48.8	6-8 hours
Hernioplasty (TAPP, TEP)	16	14/2	51.3	6 hours

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Laparoscopic donor nephrectomy

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Aim: Laparoscopic donor nephrectomy (LDN) has gained popularity throughout the world recently. Although LDN has many advantages over open donor nephrectomy such as early recovery, less long-term postoperative complications, better cosmesis and shorter hospital stay for the donors. The aim of this paper is to present the uniq LDN series in our country.

Method: Fourty living laparoscopic donor nephrectomies have been performed between November 2000 and September 2003. All the procedures were performed via transperitoneal approach.

Results: The mean duration of the donor surgery was 246 min (max 420, min 190). The mean warm ischemia time was 4 min 40 sec. In 7 patients right sided, in 23 patients left sided nephrectomy was performed. Laparoscopic nephrectomy was converted to open procedure in eight donors (20 %). Intraoperative bleeding (3 major, 1 minor bleeding) was the most common cause for conversion. The other reasons were diffuculty in diection in 3 patients, and technical in 1 patient. Postoperative urinary complications were seen in 17.5 %, vasculary complications in 12.5 % of the patients. Lengths of hospital stay of the donors was 3.3 days.

Conclusion: Laparoscopic donor nephrectomy was preferred in more and more patients, as experience grew, due to the charm of short hospital stay, less postoperative pain, scar and incision morbidity. In our transplantation clinic, as our surgeons gained experience in various laparoscopic general surgery procedures in the last ten years, LDN was started first with selected patients, than on routine basis.

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Laparoskopik fundoplikasyon: ilk 23 olgudaki sonuçlarımız

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AMAÇ: Laparoskopik Nissen Fundoplikasyonlu olgularimizin sonuçlarini sunmak

METOD: Ekim 2000 – Temmuz 2003 tarihleri arasinda gastroözofageal reflü (GÖR) hastaliği nedeniyle laparoskopik Nissen fundoplikasyonu yapılan 23 hastanin kayıtları retrospektif olarak değerlendirildi ve telefon görüşmesi ile son durumlari soruldu.

SONUÇLAR: Olgularımızın 13'ü erkek, 10'u kadindi. Yaş ortalaması 44.8 ± 10.8 (30-70) idi. GÖR'lü 23 hastanin 19'unda özofajit, 13'ünde sliding hiatal herni, 2'sinde Barret özofagus bulunmaktaydı. Tüm olgularin ameliyatı laparoskopik olarak tamamlandı, 2'sinde kolelitiazis nedeniyle kolesistektomi de yapıldı. Perop. komplikasyon, reoperasyon ve mortalite olmadı. Ortalama (ort.) operasyon süresi 190.6 ± 46.1 (100 – 300) dk. ve hastanede kalış süresi 3 ± 1 (2-5) gündü. Ancak ilk 10 olgu ile bunları izleyen son 13 olgunun ort. operasyon süreleri (218.0 ± 47.9 ve 160.5 ± 38.0 dk.) ve hastanede kalış süreleri (3.7 ± 0.8 ve 2.6 ± 1 gün) arasında anlamlı fark bulundu ($p< 0,005$). Hastaların ortanca izlem süresi 5.5 (1 – 30 ay) idi.

Erken komplikasyonlar (ilk 3 ay) olarak 5 (%21.7) disfaji, 6 (%26.0) gaz – bloating, 2 (%8.6) ishal görüldü. Geç komplikasyonlar (ilk 3 aydan sonra) 1 (%4.3) 1 disfaji, 3 (%13) gaz bloating, 1 (%4.3) ishal olarak belirlendi. Hastalarımıza ameliyat öncesi durumları gözönüne alınarak ameliyattan memnun olup olmadıkları sorusu yöneltildiğinde; 21 (%91.4)'inden olumlu, 1 (%4.3)'inden olumsuz, 1 (%4.3)'inden kısmen olumlu yanıtı alındı.

GÖR nedeniyle laparoskopik Nissen fundoplikasyonu yaptığımız ilk 23 olguluk bu küçük seride kabul edilebilir uygun sonuçlar elde edilmiştir.

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Endoscopic perforan ven ligation

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Two cases with lower extremity perforatuar vein insuffiency those are treated with Endoscopic Perforan Vein Ligation operation are presented. Both cases are diagnosed and controlled by colour doppler ultrasound. Both cases had isolated perforan vein insuffiency. Operation times are 60 and 70 minutes. There was no complication observed peroperatively and postoperatively. Recovery time was very quick and there was no morbidity. Colour Doppler Ultrasound control showed that insuffiency problem at perforan veins solved and the superficial veneus dilatations regressed. So that for perforan vein insuffiency Endoscopic Perforan Vein Ligation will be the first choice.