EuroSciCon

DAY 1

Scientific Tracks & Abstracts

International Conference on

Physicians, Surgeons and Case Reports

November 19-20, 2018 | Paris, France

DAY 1

November 19, 2018

Sessions

Miscellaneous Novel Case Reports | Surgical Case Reports | Surgery | Pediatrics | Healthcare Management | Endocrinology Case Reports

Session Chair
Sukhbinder Noorpuri
i-GP, United Kingdom

Session Introduction

Title: Interdisciplinary team work in pelvic floor surgery, is it a goal or practice?
Ahmed Masaoud Mohamed, Tripoli University, Saudi Arabia

Title: Multiple pancreaticocolonic fistulas involving the transverse and descending colon with multiple walled-off pancreatic necrosis: Reporting of a complex case treated surgically
Khaled E Elshaar, King Fahd Central Hospital, Saudi Arabia

Title: Can almost-fully gangrenous midbowel completely survive
Hamid Qoura, Nizwa Hospital, Oman

Title: Challenges in hypospadias surgery
Ahmed Masaoud Mohamed, Tripoli University, Saudi Arabia

Title: Abnormal contents of female inguinal hernia of an infant
Hamid Qoura, Nizwa Hospital, Oman

Title: A difficult case of diabetic ketoacidosis
Hannah C. Tan, St George's, University of London, United Kingdom

Title: The role of yoga in removing stress
Aditya Narayan Tripathi, Sant Tulsidas P.G. College, India

Title: An uncommon cause of low serum alkaline phosphatase
Janet Bolaji, Frimley Park Hospital, UK

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Ahmed Masaoud Mohamed et al., Med Case Rep. 2018, Volume:4
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INTERDISCIPLINARY TEAM WORK IN PELVIC FLOOR SURGERY

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Introduction: Pelvic floor is a very narrow space and contains many organs closed to each other. These many different organs are managed from different specialties depending on clinical picture or defect. In fact any weakness or defect will affect all organs in the pelvis in different levels which means management of this group of diseases should be through a team including general surgeon, urologist, and gynaecologist and may be some others as per need.

Purpose & Objectives: The aim is to highlight the importance of interdisciplinary clinical team work for management of the pelvic floor defects and its impact on clinical and surgical outcome.

Methods: Summary of the literature in this regard together with our experience in team work for managing pelvic defects.

Discussion: The descent of the pelvic floor usually affects more or less all the pelvic organs irrespective of the clinical picture of the patient. The mild to moderate defects not related to the specialty field of the treating physician could be difficult to detect or to deal with will without having the opinions of the other colleagues of interest. The pre/intra/and post-operative consultation at the right time can improve the clinical and surgical outcome and may avoid or reduce the complication risk before occurring.

Results: Establishment of pelvic floor centres like that practised in the German system seems to be an effective way of better preoperative assessment and postoperative results. This clinical team may include general surgery, urology, gynaecology and as per need neurology, spine surgery, psychiatry and dietician. Detection of hidden pelvic floor defects will be easier and earlier through this combined team work. The continuous interdisciplinary management in the pre-intra-and-post phase seems to improve the clinical and surgical outcome. This multidisciplinary group work as it takes care of all pelvic organs at the same time can reduce the complications risk.

Conclusion: Preoperative interdisciplinary team assessment and cooperation of the all involved surgeons/physicians (pre/intra/and postoperatively) seems to improve the clinical and surgical outcomes and reduce the risk of complications.

Biography

Ahmed Masaoud Mohamed has completed his Medical Study at University of Tripoli, Libya. Then he finished his urological training and got his German Board and the European Board Urological Qualification in 2007, from Witten/Herdecke University in Germany and Postdoctoral Studies from the same University. He is a Consultant Urologist since 2009, now he is practicing as an Asst. Professor at Al-Faisal University, Riyadh, KSA. He has published many papers in reputed journals and has shared in many international congresses.

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MULTIPLE PANCREATICOCOLONIC FISTULAS INVOLVING THE TRANSVERSE AND DESCENDING COLON WITH MULTIPLE WALLED-OFF PANCREATIC NECROSES: REPORTING OF A COMPLEX CASE TREATED SURGICALLY

Khaled E Elshaar, Alaa A Hakami, Ahmed M Osman, Laila H AbuAleid, Mohammed A Abdulmughni and Shaima A Maghadi

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Context: Pancreaticocolonic fistula is a rare and potentially critical complication of necrotizing pancreatitis. We report a complex case of multiple pancreaticocolonic fistulas that was successfully treated with extended left hemi colectomy.

Case Report: A 43 years old male patient, presented in our emergency department with epigastric pain, vomiting, diarrhea and weight loss for 4 weeks duration, with past history of acute gall stone pancreatitis 10 weeks earlier. Contrast enhanced CT abdomen showed multiple walled-off pancreatic necrosis in the peripancreatic, right paracolic and left paracolic regions up to left inguinal region with extensive pneumoretroperitoneum. The periduodenal collection caused duodenal compression. Laparotomy done for pancreatic necrosectomy, relieving the duodenal compression, and drainage of all collections. We noticed multiple pancreaticocolonic fistulas, 5 in numbers, between the transverse and descending colon and their neighbouring collections, extended left hemicolectomy done. Multiple abdominal drains had been put for continuous postoperative irrigation. The patient was discharged home but after 3 months of a hectic post-operative course. To the best of our knowledge, this is the first case to be reported in the literature with multiple walled-off pancreatic necroses associated with multiple pancreaticocolonic fistulas (5 in numbers) in both transverse and descending colon.

Conclusion: Necrotizing pancreatitis is a devastating disease, the presence of pneumoretroperitoneum does not essentially only point to infected necrosis, but the possibility of pancreaticocolonic fistula should always be kept in mind and searched for.

Biography

Khaled Elshaar, MBBCH, MS, MD, MRCS Eng, is a Egyptian Consultant for General and Colo-rectal surgery with special interests in Laparoscopic and Trauma Surgery. He has graduated in 1995 from the Faculty of Medicine, Alexandria University, Egypt. His Magister, MS, and Doctorate MD, were in the field of Colo-rectal Surgery. He has worked for few years in the Alexandria University Teaching Hospitals, Egypt; later moved to Saudi Arabia, where he is working as a Consultant Surgeon in King Fahd Central Hospital Jazan, since 2004 till date. He is a Member of EAES and Egyptian society of colorectal surgery as well as an Editorial Board Member in scientific Journals. He had published his researches in the field of GIT surgery, and currently, working on rare cases reports to be published.

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CAN ALMOST-FULLY GANGRENOUS MIDGUT, COMPLETELY SURVIVE?

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A case of duplication cyst presented with almost fully gangrenous midgut in a neoborn. Gastrointestinal (GI) duplications are rare congenital malformations that may vary greatly in presentation, size, location, and symptoms. GI duplications may present as solid or cystic swelling, intussusception, perforation, or GI bleeding or very rare volvulus. In our case, a neoborn presented with intestinal obstruction and investigations pointed to intestinal obstruction due to duplication cyst. Laparotomy findings showed near total midgut volvulus causing strangulation with subsequent almost fully gangrenous bowel and a large duplication cyst at the proximal jejunum. Bowel colour did not improve after about one hour of de-rotation, warm fomentation and increased O_2 supply. Depending on specific criteria, we resected only the duplication cyst and we did primary intestinal anastomosis. Abdomen was closed without a drain. We put specific parameters for post-operative observation and explained to parents that we will observe and may need re-laparotomy after 48- 72 hours if there is deterioration of the vitals, deranged investigation parameters and/or worsening of general condition of the baby. Baby improved and bowel survived. Barium meal follows through after one year showed normal bowel distribution and peristalsis. This is the first case report in such pathology and may change the view of management of near fully gangrenous bowel not improving with intraoperative manipulation.

Discussion: We reviewed articles on duplication cyst and its complications, Also articles in midbowel gangrene and its management and the prognosis.

Conclusion: The criteria which were used in taking the decision to close the abdominal cavity, were the first time to be used in such highly compromised, ischemic bowel: arterial pulsation of the mesenteric arteries started to be felt; the colour still dark but spots of pinkish discolouration appeared (Figure1); little venous blood ooze, at the cut edges of the intestine, no need to wait for arterial bleeding; weak or no clear peristalsis; the bowel doesn't look mummified or 100% dead on benching it. The use of post-operative monitoring method is commonly used in critical patients. Full counselling to the parents in all points is a must. The success of this case deserves applying these criteria in cases of almost fully gangrenous bowel especially in such cases because removal of the affected midgut bowel will end in short bowel syndrome with its known morbidity and mortality. Also keeping the bowel in the abdominal cavity without full closure will add morbidity and will prevent the full natural environment of the bowel for survival, which I think was the main factor for the bowel to regain its viability in our case. We need more cases to prove these criteria in such conditions.

Biography

Dr Hamid Qoura, is Graduated from Kasr El-Aini medical school, (Faculty of medicine Cairo University) 1983. Finished his Master degree from the same college. Had MRCS from Ireland and FEBPS from Glasgow. Had a diploma in laparoscopic surgery from Strasbourg, France. He is working at present as a consultant and HOD of Pediatric Surgery in Nizwa Hospital, Oman. He published more than 10 papers in reputed Journals. Has special interest in laparoscopic surgery. He is the first one did real single port laparoscopic umbilical hernia, epigastric hernia and divarication of recti repair. And can do throus the same port inguinal hernias of the same patient.

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CHALLENGES IN HYPOSPADIAS SURGERY

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Introduction: The treatment of hypospadias is full of challenges not because of the operation technique itself but because of some other factors like: delayed diagnosis, continuation of regular long term follow up and relative high complications.

Objectives: A summary of the possible challenges we may face in managing hypospadias patients from birth till adulthood.

Methodology: Collection of personal experience and literature regarding hypospadias management and its challenges with some suggestions to deal with these challenges in better way.

Discussion: Many known surgical procedures have been established for hypospadias. The selection of the right procedure each patient is an individual decision which varies with location of urethral orifice, other associated problems and center experience and this decision is usually taken intraoperatively. The management of theses patient should also include the psychosocial aspect and the continued education of the patient and family.

Results: It is valuable that every surgeon dealing with hypospadias has to be aware of these challenges and how to manage them. The management of other aspects like psychosocial support should be considered.

Conclusions: A comprehensive knowledge of these challenges and their management is necessary for every surgeon dealing with these patients. Management of hypospadias is not only the surgical procedure but it includes at the same time the long term follow up, psychosocial support and continuous patient and family education.

Biography

Ahmed Masaoud Mohamed has completed his medical study at University of Tripoli, Libya. He then finished his Urological Training and got his German Board and the European Board Urological Qualification in 2007, from Witten/Herdecke University in Germany and Postdoctoral Studies from the same University. He is a Consultant Urologist since 2009, now he is practicing as an Assistant Professor at Al-Faisal University, Riyadh, KSA. He has published many papers in reputed journals and has shared in many international congresses.

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ABNORMAL CONTENTS OF FEMALE INGUINAL HERNIA OF AN INFANT

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Background: The presence of all the gynecological organs in one side of female inguinal hernia is very rare. Such findings in published papers are very few. The diagnosis of such cases needs a high suspicion and is not necessary to do ultrasound or CT scan unless there is a debate of the nature of the contents.

Case report: Here in, we present a three months old female infant presented with irreducible left inguinal hernia. The patient has history of reducible left inguinal hernia since birth. The content was a reducible ovary. She was given appointment for surgery but one week before surgery; appointment presented with one day history of large left groin swelling, irreducible that suggested that the contents are gynecological organs. Decision was taken for surgical exploration without doing a pre-operative ultrasound or CT scan. We explained to the parents, the possibility of finding torsion of an organ of the contents which may necessitate its removal and the consent was taken. Operative findings were the uterus, the two fallopian tubes and its two corresponding ovaries were herniated out in the sac. Left ovary and tube were sliding. They were in an inflamed condition with deep yellow serous fluid in the sac. The ovaries were multi-cystic (multiple small cysts in both ovaries). All organs were reduced to the abdominal cavity in specific sequences after widening of the internal ring with a lateral incision. High closure and excision of the hernia sac was done. Then repair of the defect was done and followed up for six months. Ultrasound showed normal female organs in normal position.

Discussion: Although this case appears simple but it has many challenges or difficulties which should be considered in dealing with it. The first challenge was in proper time of diagnosis to avoid torsion of one or both ovaries or even the uterus. The other challenge is in dealing with the contents pre-operative; don't try to aggressively reduce the contents to avoid injury or torsion to these important organs. The third challenge is inter-operative as the contents are large and inflamed, while the neck of the hernia is narrow, so it needs a special technique and maneuver to reduce them in safely.

Conclusion: We prove that good clinical evaluation can be enough and no need for ultrasonography or CT scan to reach a diagnosis or to take a decision for surgery in case of irreducible female inguinal hernia. This condition is very rare which needs good clinical expectation and gentle manipulation in reducing the contents inter-operative. We advise to use the sequence we used to reduce the herniated contents into the abdominal cavity following the role saying; last organ came out is the first organ to go in. We expect that the left ovary (ipsilateral ovary) came out first then the uterus which pulls the right ovary up. So the last content herniates is the contra-lateral ovary, hence has to be the first to go in. Also don't hesitate to widen the internal ring to avoid hard manipulation on reduction and the consequent organ injury.

Biography

Dr Hamid Qoura, is Graduated from Kasr El-Aini medical school, (Faculty of medicine Cairo University) 1983. Finished his Master degree from the same college. Had MRCS from Ireland and FEBPS from Glasgow. Had a diploma in laparoscopic surgery from Strasbourg, France. He is working at present as a consultant and HOD of Pediatric Surgery in Nizwa Hospital, Oman. He published more than 10 papers in reputed Journals. Has special interest in laparoscopic surgery. He is the first one did real single port laparoscopic umbilical hernia, epigastric hernia and divarication of recti repair. And can do throus the same port inguinal hernias of the same patient.

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A DIFFICULT CASE OF DIABETIC KETOACIDOSIS

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Diabetic Ketoacidosis (DKA) is a preventable and life-threatening complication of Type 1 Diabetes Mellitus. It is a metabolic state with a diagnostic triad of hyperglycaemia, acidosis and ketonuria. In this tragic case, a young 23year old patient presented to the Emergency Department with severe diabetic ketoacidosis, septic shock and intra-uterine death at 33/40 – and was subsequently managed in the Intensive Care Unit. We examine the precipitating biopsychosocial factors contributing to this unfortunate event, discuss the pathophysiology and complications of diabetic ketoacidosis, and highlight recent advancements in the management of this common medical emergency.

Biography

Dr Hannah Tan completed her MBBS from St. George's, University of London in 2016. Prior to this, she attained BSc (Hons) Biomedical Science in 2010 from University of Southampton and as a musician DipLCM Piano from the London College of Music in 2012. Her Foundation Training was at Epsom & St Helier University Hospitals NHS Trust where she developed an interest in Emergency Medicine and Critical Care. She was a recipient of Merit Award of Clinical Excellence from South Thames Foundation School in 2018.

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THE ROLE OF YOGA IN REMOVING STRESS

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Background: Yoga is said to have originated in India during golden age, nearly 26000 years ago. It is integral subjective science. According to lord Krishna "yogah karmasu kaushalam", that is to say skill full work is yoga. Patanjali has told in yogasutra "yogah Chitta vritti Nirodhah" that is to say with stand mind towards world. Human being are made of three components body,mind and soul. Corresponding these there are three needs health knowledge and inner peace. Today we are living in the age of explorations and explosion of knowledge. Due to ever increasing ambitions, desires, and competitions, restiveness and tensions have also increased by leaps and bounds. The modern world which is said to be world of achievements is also a world of stress (Kaul 1989).

Concept of stress: Warr and Wall (1975) defined stress in term of an individual's experience of tension , anxiety fear discomfort and associated psychological disorders resulting from aspects of work situation which depart from optimum (either too little or too much work). Jarry and Jary (1995) told that stress is a state of tension produced by pressure or conflicting demands with which the person cannot cope adequately.

Steps of yoga: according to Vedant yoga means supreme realization. Yoga is the reunion of the living self with the supreme self. Yoga dose not believe in the temporary cure of the patient because "the old troubles often reappear in different forms". It therefore prescribes eradication of mental conflicts unpleasant urses and tendencies through yogic methods. It claims complete cure of neurotics and psychotics by yogic exercise.

Patanjali has told eight steps of yoga:

(1) Yama refers to abstain from violence

(2) Niyama : is the second step refers to observance of purity

(3) Asana are physical posture

(4) Pranayama refers to control to inhale and exhale.

(5) Pratyahar withdrawl of the mind (senses) from objects.

(6) Dharana refer to concentration.

(7) Dhyana uninterrupted focuses of the mind on one point.

(8) Samadhi deep meditation is final stage.

Result: It was found that those who have done yoga they have succeeded to remove their stress.

Biography

Aditya Narayan Tripathi is an Associate Professor in education department at Sant Tulsidas PG College Kadipur Sultanpur which is affiliated to Avadh University, Faizabad, UP India. Many research papers are published and attended many international and national conferences in USA, Canada, United Kingdom, Italy, Thiland, Nepal and in India too. He is an Editor in Oceanography and petrochemical sciences in USA; an Associate Editor in Global Journal of Intellectual and Developmental Disabilities in USA. He is Convener of Education Department in Avadh University Faizabad and also Member of Indian Academy of Health Psychology. He is an Editor of daily and weekly newspaper, Aditya Times and Founder of Degree College, Secondary School, Primary & junior High school as Karmyogi Ram Surat Tripathi Mahavidyalya, Maharshi Dayanand Inter college, Swami Vivekananda Convent Junior High school & Swami Vivekananda Convent primary school, etc. He is an Ex-Senior Vice President of Teachers Association of Avadh University Faizabad and Secretary of Press club, Ambedkar Nagar, UP, India.

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AN UNCOMMON CAUSE OF LOW SERUM ALKALINE PHOSPHATASE (ALP)

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Introduction: A 46 year old female was referred to the metabolic medicine clinic for evaluation. She was referred via her general practitioner with persistently low alkaline phosphatase (ALP) levels which were first noticed during an occupational medical assessment. There was no personal history of fractures or arthritis and no family history of fractures or dental issues. Commonly considered conditions associated with low serum ALP include coeliac disease, micronutrient deficiency, Wilson's disease, drug therapy, anaemia and hypothyroidism.

Results: On review, serum ALP was noted to be chronically between 15-20 IU/L (reference range 30-130 IU/L) and this had been the case for as far back as results were available which was preceding 13 years. Laboratory testing for free T4 and TSH were normal. In addition, tests for serum copper, ceruloplasmin levels, tissue transglutaminase antibodies, vitamin B12, folate and magnesium levels were all also unremarkable. Zinc was had been previously low but she had been started on supplementation and levels had normalised by the time of review. Serum vitamin D was mildly low at 59 nmol/L (reference range is 75-200 nmol/L) and supplementation did not affect her low serum ALP levels. X-ray imaging of the knees revealed no evidence of chondrocalcinosis. Serum pyridoxal phosphate levels were elevated at 161.4 nmol/L (reference range 35-110 nmol/L) and also combined with low alkaline phosphatase which was suggestive of primary hereditary hypophosphatasia. This patient was referred to a tertiary centre, and urinary phosphoethanolamine was deemed unnecessary, since it is often normal in patients with hypophosphatasia. This patient went on to be referred for genetic testing and family screening.

Conclusion: Primary hereditary hypophosphatasia was initially considered to be an unlikely diagnosis for this patient since she had been asymptomatic and did not present with the typical bony symptoms or complications. Monitoring is usually recommended in patients with primary hereditary hypophosphatasia and thus, recognition of the condition can have important implications for patients and their families. Therefore, although uncommon, it is a key diagnosis to bear in mind.

Biography

Janet Bolaji has completed her BSc in Physiology at King's College London in addition to her primary medical qualification from Swansea University. She completed her Foundation Training at Frimley Park Hospital and St Helier Hospital. Her rotations included Chemical Pathology and General Medicine. She has an interest in Endocrinology and Nutritional Medicine and is furthering this interest by completing a Masters' degree at University College London (UCL). She also has an interest in medical education and enjoys organising teaching sessions for medical students.

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