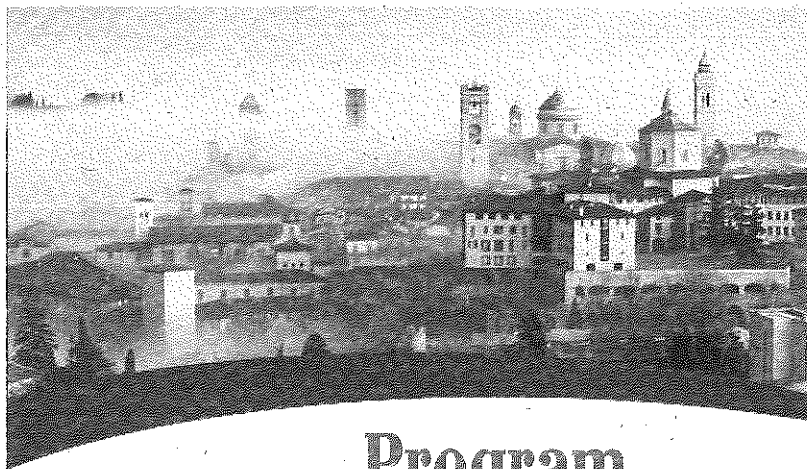




World Journal of Emergency Surgery

World Society of Emergency Surgery



**Program
&
Book of Abstracts**

**2ND WORLD CONGRESS
BERGAMO
JULY 7-9, 2013**

Chairmen: L. Ansaloni, F. Catena, E.E. Moore

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SCIENTIFIC PROGRAM

**UNA Hotel
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BLEEDING CONTROL OF AN AORTOESOPHAGEAL FISTULA WITH A SENGSTAKEN-BLAKEMORE TUBE

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Introduction: Aorto-esophageal fistulas (AEF) are relatively rare but life-threatening causes of upper gastro-intestinal bleeding, causing massive exsanguination. AEF may be primary or secondary. The majority is secondary and usually occurs in a setting of prior aortic reconstructive procedures. Transient self limited "herald bleed" may precede exsanguination. A Sengstaken-Blakemore tube can be life-saving as a first procedure, apart from the potential complications of its use, like esophageal and gastric ulceration and perforation, bronchoesophageal fistula and acute airway obstruction.

Methods: A 48-year-old male patient with known pré-existing chronic hepatic disease and esofagogastric varices underwent emergency stent graft placement because of rupture of a proximal descending aortic aneurysm. A few hours later the patient produced massive bright red hematemesis covering the bed and the near floor of the ICU. This emergency situation has been controlled by immediate endotracheal intubation, fluids and the successful introduction of a Sengstaken-Blakemore tube.

Results: The endoscopic control, next day, showed the origin of the bleeding was not the varices but an AEF related with the ruptured aneurism.

Conclusions: A Sengstaken-Blakemore tube can be life-saving as a first procedure, apart from the potential complications of its use, like esophageal and gastric ulceration and perforation, bronchoesophageal fistula and acute airway obstruction.

DISPHAGIA AND EMERGENCY

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Introduction: Actually the oesophageal and cardiac carcinoma is a high morbidity and mortality disease too. The main reason is a underestimated disphagic disease with a delayed clinical evaluation. The result is a very low quality of life and severe mortality. The purpose of this study was to reduce the high grade of the disphagia and improve the quality of life in patients affected by oesophagus cancer stenosis using a MultiDisciplinary Therapeutic Approach.

Methods: In our last University Endoscopic Ambulatory, during 10 years, we observed 135 patients affected by oesophageus disease. The grave or severe disphagia was the more frequent symptom. Sometime, there were other symptoms linked to disphagia (tab.1). The 89% cases arrived to our evaluation without an adequate clinical-endoscopic-radiological documentation. All had previously been treated with anti H2 and pro-kinetic drugs for several months. We observed. 1) Primitive Neoplasm (78/120 p.=65%). 2) Secondary Neoplasm (12/120 p.= 10%). 3) Neoplastic Recurrences (17/120 p.=14.5%). 4) Flogistic Disease (5/120p.=4.16%). 5) Achalasia (5/120p.=4.16). 6) Barrett's Disease (3/120p.=2.5%) (tab.2-3). Male/female ratio was 2.5/1. Various risk factors were classified (smoke=60%, Alcohol intake over 1000cc/die=60%, Obesity=25%, Barrett =2.5%) (tab.4) All the patients were valued with accurate clinical evaluation using a Multianalises Score System (tab.5-6-7-8-) In evaluating operability, we considered several parameters concerning the General Clinical Status and the Neoplasm Stage (TNM) (tab.9-10-11) Surgical treatment was established for only a few patients (15/135) which might gain advantages one-step open-surgical oesophagectomy, alone or combined to chemo-radio therapy, in according to international literature. The others 120 patients with disphagia (IIIrd level=80 p., IVth level = 40 p.) were valued no-responders to classic open-VLS Surgery (tab.12-13). They were treated with ELS (Endoscopic Laser Surgery) alone or combined to others treatments (EGDS Savary Dilatation, Endoprosthesis, X-Rays Therapy). Flexible fibre CO2 Laser and single-use pinches were employed to perform this kind of treatment. The Endoscopic Laser Energy was administered with a continuous power flow (20-40 Watts) and mixed Technique. We used a specific treatment to single patient and disease. The single dose ranged 800-2000 Joules. The procedure was cyclically repeated every 15-60 days. The Total Dose ranged 2000-6000 Joules. In general, we preferred the EGDS Savary Dilatation before the LES and positioning self expanding covered or non-covered stents (102) after ELS according Radiologist colleagues. If necessary, RadioTherapy (mean dose 39 Gy) was associated too.

Results: We obtained a total recanalisation in flogistic disphagia disease. We obtained an important recanalisation in the first 12 months in the 85% of the neoplastic stenosis and an enough recanalisation in the 60% of the cases between 12-24 months from the first treatment. After 24 months, we obtained an useful canalisation only in the 30% of the cases (tab.14). We registered some complications link to the treatment. (tab.15). The only one intra-operative death was in a 78 y. old patient affected by cardiomegaly. Probably, the cause was an arrest hearth because of the fatality laser energy propagation. So, the mortality for this laser-surgery treatment was lower than 1% and also the morbidity was reduced when compared to the other centers 'dates. We registered oesophagus Iatrogenous perforations (3) too. These healed spontaneously after specific therapy (2) using thoracic drainage, antibiotic drugs, total parenteral nutrition). It has been necessary to place only one covered endoprosthesis. Our protocol provided a 3-years follow-up with long term survival ranging 30-900 days.

Conclusions: ELS could be considered the main treatment to inoperable oesophageal cancer. According our dates we think that the Treatment don't influence the survival, reduces absolutely the disphagic symptoms and improve the quality of life. The Cost/Benefit is profitable too. (tab.16) Tab.1 Symptom % Dysphagia 78 Epigastric pain 6 Heatburn 3 Weight loss only 3 Odinophagia 2 Vomiting/Regurgitation 2 Fatigue 2 GastroIntestinal bleeding 1 Nausea 1 Indigestion 1 Sore throat 1 Tab.2 Patology Diagnosis n.patients % Primitive Cancer 78 65 Secondary Cancer 12 10 K. Recurrences 17 14.5 Flogistic disease 5 4.16 Achalasia 5 4.16 Barrett'esophagus 3 2.5 Tab.3 Primitive Cancer n.patients % Cervical esoph. 10/78 12.8 Thoracic 17/78 21.7 Cardias 51/78 66.5 Tab.3 Secondary Cancer n.patients % Cervical esoph. (from laringeal K.) 7/12 58.2 Cardias (from lung-mediastinic K.) 5/12 39.7 Tab.4 Risk Factors Smoke 70 % Alcohol 60 % Obesity 30 % Barrett's esophagus 2.5 % Tab.5 Clinical Evaluation General Status Pulmonary Function Cardio-Vascular Function Hepatic Function Renal Function Neurological Function Diabetes Tumor Stage Tab.6 Clinical Evaluation - General Status Sex Age Karnofsky Index Alcohol Abuse Tobacco Abuse Weight loss Dispepsia Mental Cooperation Blood examination Tab.7 Clinical Evaluation - Pulmonary/Renal Function Vital Capacity V.C Focal Expiratory Volume FEV 1 Peak Flow PaO2 mm/Hg PaCO2 mm/Hg Creatinine Clearance mg/ml Tab.8 Clinical Evaluation - Cardiac/Hepatic Function ECG X-rays Chest Cardiologist Visit Serum Albumin Bilirubin P.T- P.T.T Aminopyrine Breath Test Cirrhosis Tab.9 Clinical Evaluation - Mental cooperation / Risk Karnofsky Index > 80 & good cooperation / Normal Karnofsky Index < 80 & good cooperation/ Compromised Karnofsky Index < 80 & bad cooperation/ Severely impaired Tab.10 Clinical Evaluation - Cardiac Function / Risk Normal Normal Compromised Increased Severely impaired Highest Tab.10 Clinical Evaluation - Pulmonary Function / Risk VC > 90% PaO2 > 70 mm/Hg Normal VC < 90% PaO2 < 70 mm/Hg Compromised Tab.11 Clinical Evaluation - Hepatic Function / Risk ABT > 0.4 Normal ABT < 0.4 no Cirrhosis

Compromised Cirrhosis Severely Impaired Tab.12 Conditions for inoperable patients III th Stage Neoplasm T3 N2 M0-1 Age over 75 Cardio-Vascular disease Coagulopaties Weight loss Immuno Compromised Tab.13 Pre-Operative Disphagia Patients III grade IV grade 120 80 40 Tab.14 Post-Operative Disphagia grade % n.patients Follow-up/months I 85 102/120 <12 I 60 72/120 >12 <24 II 30 36/120 >24 Tab.15 Intra-Peri Operative Complications n.patient % Exitus 1/120 0.83 Iatrogenous perforation 3/120 2.5 Re - Stricture (after RadioTherapy) 2/120 1.66 Tab.16 Cost effectiveness in the management of oesophageal K. Surgery RadioTherapy Laser Stents No Treatm. Median Cost \$ 8070 4720 3520 2450 1390 Range 2540-39780 3364- 6687 2530- 6340 1647- 5550 1132- 2348 Cost /month Survival 457 364 342 //