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ABSTRACTS

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colorectal cancer carcinomatosis, 5 with abdominal mesothelioma, 5 with carcinomatosis of other origin) with a cardiac ejection fraction >40 and Karnofsky Performance Status >80 received a Denver peritoneojugular shunt as an outpatient procedure under local anesthesia and mild sedation. Jugular vascular access was achieved via ultrasound-guided venipuncture.

Results: The average operating time was 30 minutes. Vascular access was through the right jugular vein in 87 patients and the left jugular vein in 11. The success rate of venipuncture and the operation was 100%. The mean postprocedural observation period was 180 minutes. Hemorrhagic suffusion occurred in 12 patients; no other major complications were observed. The waist circumference decreased within 3 hours of shunt placement; 4 patients required mild abdominal compression. The percentage of patent shunts at 30 days postimplantation was 75% (74/98) and 70% at 60 days. In 20 patients the shunt was removed due to valve failure or peritoneal catheter occlusion, with subsequent conversion to open percutaneous drainage. No thrombotic complications occurred in the district of the superior vena cava.

Conclusions: Our experience demonstrates the feasibility of performing peritoneovenous shunt placement on an outpatient basis in selected patients and with use of ultrasound-guided venipuncture. The high success rate confirms that it is an effective palliative procedure for treating intracavitary malignant ascites.

Pelvic evisceration for pelvic neoplastic disease: Our results

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Background: Oncologic surgeons face the challenging problem of patients with locally advanced neoplastic (primary or recurrent) pelvic disease recalcitrant to cancer therapies and tending to be locally bulky and highly symptomatic.

Methods: Between May 2010 and March 2012, 8 patients (5 females and 3 males; mean age, 50.5 years) underwent pelvic evisceration with curative intent (complete in 7 patients, posterior in 1 patient) for neoplastic disease (recurrent rectal adenocarcinoma [n=3], primary locally advanced rectal adenocarcinoma [n=1], squamous cell cervical carcinoma [n=1], endometrial cancer [n=1], ovarian cancer [n=1], squamous cell keratinizing perianal carcinoma [n=1]) by the same skilled surgical team. Four patients were treated with neoadjuvant chemotherapy.

follow-up of 7 months, 5/8 (62.5%) patients are alive and 3/8 (37.5%) alive and disease free, 2/5 patients are alive with recurrence: 1 distant (hepatic) and 1 local (head of femur). Recurrence of disease was observed in 5/8 (62.5%) patients: local in 3/5 (60%), isolated distant in 1/5 (liver) (20%), and distant diffuse and local in 1/5 (20%).

Conclusions: Pelvic evisceration resolves troublesome symptoms in patients with pelvic neoplastic disease not controlled by therapy, increasing their quality of life, with zero mortality and acceptable morbidity. The survival benefit doesn't seem to be high, but more data and studies are needed.

Reliability and safety of the echo-guided procedure of mid- and long-term totally implantable system positioning in the path to learning the techniques

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Background: The authors analyze their experience with the positioning of totally implantable central venous access, stressing the importance of the systematic use of ultrasound for vascular assessment and venipuncture in learning the methods to be used and in order to control immediate complications.

Methods: From 1 January 2007 to 31 December 2011 we placed 312 Port-a-Cath devices under ultrasound guidance (185 women, 127 men). The use of ultrasound allowed us to perform venous cannulation with a single venipuncture in 82% of cases. Surgical isolation of the vessel was required in only 1 case due to an unfavorable position of the vein. There was only 1 case of an early complication (formation of a layer of pneumothorax) but it did not require chest drainage aspiration. The catheter had to be removed in 8 cases because of late onset of infection in 6 and skin necrosis in the pocket of the reservoir in 2.

Results: The procedure was ordinarily performed under local anesthesia in day surgery, except in patients whose port placement had been planned for oncologic operations under general anesthesia. The technique involves cannulation of the vein under ultrasound guidance using a 10 MHz linear transducer. A preoperative ultrasound of the neck allows direct visualization of the vein and its exact location and morphology. The most often used access was the right internal jugular vein at the right supraclavicular level. Device implantation is carried out under fluoroscopy control in the operating room in order to assess correct positioning of the catheter tip after cannulation, which must be pre-atrial. The pocket for positioning the reservoir is generally located at a right subcutaneous subclavicular level in the parasternal area. Subsequent chest radiographs in 2 projections

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