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Reconstruction surgical techniques for pelvic exenteration and vaginectomies

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We are currently using two surgical techniques for pelvic reconstruction at Central Military Hospital in El Salvador. We achieved excellent results after the completion of vulvectomies, vaginectomies, radical hysterectomies and pelvic exenterations. These surgical procedures are: 1) Laparoscopic vaginal diverticulization of a minimum remaining of vagina for the formation of a neovagina. When a radical hysterectomy (Piver IV type) was performed and the vagina was resected almost completely, we proceed to place a glass marble to pull the vaginal remnant using two thick sterile strings located by laparoscopy at the pre-peritoneal space using two mini graspers and then the strings are externalized and tied to a device for adjusting the tension of the strings gradually. The progressive traction on the vaginal mucosa remnant gives rise to the formation of an extra-peritoneal diverticulum which functions as a neovagina; and 2) the formation of a new pelvic diaphragm from a defunctionalized segment of sigmoid colon after pelvic exenteration. A segment of sigmoid colon preserving its vascularity is defunctionalized and it is opened longitudinally at its anti-mesenteric border. The intestinal mucosa is removed by hydro-dissection and the open segment of sigmoid colon is applied to the pelvic cavity. Thus, a viable new pelvic diaphragm is created which has muscle and serous layer. Hence, this has reduced substantially the risk of perineal dehiscence.

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Upper extremity fistulogram and intervention: Benefits of internal jugular venotomy approach

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Fistulogram with intervention is traditionally performed via direct access into the graft or the fistula outflow vein in the patient's upper extremity. Repeated direct intervention places the fistula/graft at increased risk for pseudoaneurysm, infection, stenosis, or other complications, which may ultimately lead to access site failure. Furthermore, if the intervention fails, there is added cost and risk when a second procedure and access is required for placement of a dialysis catheter. Here we advocate an alternative approach to performing upper extremity fistulogram, using the internal jugular vein as the access site for intervention on both the fistula and the central venous system. This method results in less risk for injury or infection to the access site related to direct puncture, obviates the need for a second venotomy, and potentially may result in less radiation exposure and discomfort to the patient.

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