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Review of labia minora labiaplasty - past, present & future

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Background: Labia minora labiaplasty is becoming a more frequently requested cosmetic procedure. In 1976, Radman first described labia minora labiaplasty. Since that time, different surgical techniques have been published and non-surgical procedures have been introduced. These cosmetic procedures remain controversial because of deceptive marketing practices and the lack of evidence-based medicine to support them.

Objective: To review the existing surgical and non-surgical methodologies of labia minora reduction literature with emphasis on surgical outcome and patient satisfaction.

Methods: Electronic and manual literature searches were conducted on labia minora reduction in the English language utilizing Google Scholar from 1970 to December 2017. A targeted methodological review and analysis of surgical and non-surgical techniques was appraised.

Results: Several published articles in peer review journals and anecdotal information on labia minora reduction surgical and non-surgical techniques were identified. Review of the existing literature established that the safety and effectiveness of labia minora reduction surgery for aesthetic purposes has not been determined. The non-surgical RF literature is available, but no scientific data on the safety and effectiveness of these devices is being presented. However, due to the variations in the labia minora presentation, there is not a single procedure that can be utilized for labia minora reduction.

Conclusion: Well-designed and well-executed clinical studies are needed to make appropriate clinical-scientific progress for labia minora reduction for cosmetic purposes. Furthermore, standards of care must be established by organizations, such as ACOG and ASPS, to protect women against unethical practices that put her at risk for unfavorable outcomes.

Biography

Egbert John Serrao has been a board certified solo practitioner for thirty years and specializes in Women's Health and Cosmetic-Plastic Gynecology. He has performed over 12,000 surgical procedures and has advanced training in Female Genital Cosmetic-Plastic Surgery. He is a Fellow of the American Congress of Obstetricians and Gynecologists and the American Academy of Cosmetic Surgery. He completed his residency at Maryland General Hospital and received his medical degree from the University of Maryland School of Medicine and the Autonomous University of Guadalajara. He is a former Associate Clinical Professor at the University of Central Florida School of Medicine and is the Medical Director of Serrão Rejuvenation Center.

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Longitudinal rigid sternal reconstruction: A reliable fixation technique in the setting of chest wall dehiscence and infection following cardiac surgery

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Objective: While infection following median sternotomy occurs in only a small population of patients with incidence reported at 1.32%, mortality from mediastinitis is currently reported as high as 33%. Failure of the sternum to reunite carries an incidence of 0.3-5% and increases the potential for mediastinitis. Various forms of sternal fixation have been introduced, whereas traditional sternal wires remain the most commonly used. We introduce a novel fixation technique that has been used to successfully salvage sternal fixation while treating the underlying infection.

Methods: From 2013 to 2017, eight patients met criteria of having had sternotomies with culture-confirmed postoperative chest wall infection. All patients were treated with serial debridement and culture-selected antimicrobial therapy. Once gross infection was controlled, the sternum was fixated with a rigid longitudinal plate and screws on either side of the sternotomy. Traditional sternal wires were then used to reduce the sternotomy. Using this method, longitudinal sternal fixation encompassing the entire length of the sternum was performed allowing placement of additional wires in the area of the Xiphoid process, thus extending the line of coaptation and reinforcing the lower pole of the wound, a previously unaddressed area of weakness.

Results: In all patients, the sternum was salvaged without need of sternectomy. Mechanical ventilation requirements were also minimized in between surgical procedures by providing a physiologically intact chest wall. In patients who developed infection with sternal hardware in place, successful treatment of the infection was achieved without hardware removal. No patients died from sternal wound infection in our series.

Conclusion: Sternal dehiscence and mediastinitis remain a potentially devastating complication following median sternotomy. Our technique of plate and screw fixation of the sternum united with sternal wires offers a potential reconstructive option and may assist in infection resolution, especially in the case of sternal fragmentation which is poorly handled by other modalities. The sternal plates additionally serve to secure any horizontal instability of the sternum or ribs and serve as a rigid platform for the transverse wires to purchase. Further study is required to determine the degree of long-term healing and more specific infection clearance patterns.

Biography

Jeko Madjarov is a board-certified general, thoracic and vascular/endovascular Surgeon. His clinical interests include adult cardiac and thoracic surgery; aortic surgery, including complex/endovascular aortic repair; and minimally invasive coronary and thoracic surgery. He received his medical degree summa cum laude from Sofia Medical University, Bulgaria. In the U.S., he completed general surgery residencies at Yale-New Haven Hospital, New Haven, CT; and Baystate Medical Center/Tufts University School of Medicine, Springfield, MA. He then completed fellowships in vascular/endovascular surgery and cardiovascular/thoracic surgery and at Carolinas Medical Center, Charlotte, NC. An active researcher, he is engaged in several research studies and is also involved in the development of new medical technology. He has authored more than 25 publications in peer-reviewed journals and has presented his work at more than 20 national and international medical meetings.

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Comparison of rigid versus flexible balloon catheters under image guidance navigation in transnasal dilation of the eustachian tube: A cadaver study

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Objective: To compare the feasibility and safety of rigid versus flexible catheters in Balloon Dilation of the Eustachian Tube (BDET) and evaluate the accuracy and usability of Image Guidance Navigation in BDET utilizing flexible wire technology.

Methods: Transnasal BDET was performed on eight Eustachian Tubes (ET) (four cadaver heads) under Image guidance. Utilizing image guidance navigation one flexible two rigid catheters were introduced into each ET under direct endoscopic visualization, then inflated with contrast material to a pressure of 12atm, the catheter was then secured and Computed Tomography (CT) performed. Both the CT images as well as the navigation recordings were reviewed to evaluate if inadvertent penetration into the surrounding soft tissue occurred and determine if navigation of BDET was safe and reliable.

Results: The flexible balloon catheter was able to safely cannulate all eight ET, however both rigid balloon catheters failed to stay within the ET in four out of eight procedures, penetrating the surrounding soft tissue. Both CT findings as well as middle ear examinations demonstrated that flexible navigation was able to reliably in determine the catheter position within the ET.

Conclusion: This study demonstrated flexible balloon catheters can reliably transverse the cartilaginous ET, however significant caution needs to be used when utilizing rigid balloon catheters as they have the tendency to penetrate into the soft tissue surrounding the ET. Navigation of BDET via a flexible guide wire was also shown to be reliable and accurate in demonstrating the course of the catheter through the ET.

Biography

Marc Dean is a board-certified Otolaryngologist, who graduated from Baylor University with a bioinformatics and went on to graduate from Texas Tech Health Science Center with a degree in medicine. He completed his residency at Louisiana State University Health Science Center in Shreveport, as well as his fellowship in Otorhinology under Gale Gardner and Fred Stucker. He currently practices in Fort Worth, Texas, focusing on both otologic and rhinologic disorders. He also serves as Chairman of Vitruvio Institute of Medical Advancement (VIMA), a nonprofit research institute, as well as holds clinical faculty positions at both TTUHSC and University Health Shreveport.

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Difficult cases and their clinical solution

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I believe that an orthodontist is not only a specialist dentist; he must have knowledge and interesting in art as dentistry is not about teeth treatment but also aesthetic of the face to be a successful orthodontist because science has no end. In some clinical cases in our daily practice we might face bone deficiency to replace missing teeth with dental implants instead of doing second surgery and bone augmentation. We can be more conservative depending on orthodontic means such as extrusion of hopeless teeth in other cases we can use mini implants to adjust complicated orthodontic cases and surgical cases such as skeletal open bite or interocclusal space deficiency. This lecture for Implantologist, Orthodontist & General Practitioner. In this lecture I will talk about clinical cases to show the interrelation between ortho, implant & aesthetic dentistry & aesthetic medicine (Botox & Filler) solving clinical cases with no surgery. It's for specialist dentist & general practitioner.

Cases in the Lecture

1st will cover extrusion of hopeless anterior centrals to correct bone level before replacing them with dental implant instead of bone augmentation.

2nd to gain more interocclusal space by intrusion of opposite posterior teeth.

3rd case to correct skeletal open bite by using mini implant instead of orthognathic surgery.

4th case using mini implant to align tilted teeth to provide space for implant or bridge.

5th some cases about gum smile treatment by mini implant & botox beside some cases about aesthetic dentistry.

Biography

Walid Odeh has completed his BDS at age 26 years from Nisantas Ozal Yuksek Okulu, Marmara University, Turkey. Beside that he has a master degree in Orthodontics from Baghdad University, 2000. He has a specialty expert in Implant Association/Germany. He is a fellow of ICCDE (International College of Dental Education). He is a member of ICOL (International Congress of Oral Implantologist), AAID (American Academy of Implant Dentistry) (Austrian, Turkish Jordanian & Egyptian Implant Association), European Esthetic Association, WFO (World Federation of Orthodontics), AOS (Arab Orthodontic Society), DGZI (German Implant Association), ADA (American Dental Association) and AAAM (American Academy of Aesthetic Medicine) as he is treating so many cases of TMJ disorder & gummy smile by Botox, beside he participating in many international conferences as a lecturer in many countries like USA, Germany, Jordan, Far East, Malaysia, Taiwan, Hong Kong & so many Arab countries. He is the owner of Academic Specialized Dental Center which is a unique one that has a special lecture hall supplied by high quality techniques. It's large enough to have forty dentists gathering for scientific lecture discussions and the direct transmission by special camera recording videos of operations, implants, orthodontics, cosmetics, endodontics to the lecture hall making sure that those dentists get the best learning by providing them with modern science of dentistry in addition to dental courses from time to time that are held in our center.

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Analysis of the surgical correction of VSD complicated with pulmonary arterial hypertension.

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Aim: Estimation of results of the surgical treatment of ventricular septal defects complicated with pulmonary arterial hypertension.

Materials and methods: Since January, 2012 till December 2017 in the cardiac surgery department of the National Scientific Center of Surgery named after A.N. Syzganov 152 patients underwent a surgical correction about ventricular septal defect bypass. Of them 50 patients had ventricular septal defect complicated with pulmonary arterial hypertension. There were 26 males and 24 females. The age varied from 3 months till 41 year-old (mean age – 20,7 year-old).

A surgical correction was performed by median sternotomy. The basic stage of surgery was carried out bypass machine. All patients underwent a plastic closure of the ventricular septal defect with synthetic patch. 7 patients underwent a De Vega annuloplasty and 15 patients – suture plasty due to tricuspid valve insufficiency, while the bicuspidalization of the tricuspid valve was performed in 4 patients.

Results: The pressure in the pulmonary artery was measured in order to estimate the pulmonary arterial hypertension before and after a surgical correction of the VSD. 31 patients had a pulmonary arterial hypertension of the I degree (30-50 mm per mercury by Bakulyev), of them 6 patients had an increase of the pressure in the pulmonary artery. 11 patients had a pulmonary arterial hypertension of the II degree (50-70 mm per mercury by Bakulyev). 8 patients had a pulmonary arterial hypertension of the III degree (70-90 mm per mercury by Bakulyev).

Conclusion: Patients with VSD complicated with pulmonary arterial hypertension in the postsurgical period have a high risk of the development of complications, thereby the hospital staying period increases. All patients with pulmonary arterial hypertension should accurately be examined in the postsurgical period and administered an appropriate hypotensive therapy with Sildenafil. According to EchoCG data after surgery the pressure in the pulmonary artery decreased in the second and third groups. In the first group some patients had a mild pulmonary arterial hypertension with tendency to increase (6 patients) that is probably associated with absence of the conservative therapy in the presurgical period.

Biography

Koshkinbayev Zhenis is a Cardiac Surgeon of Cardiac Surgery department at the National Scientific Center of Surgery named after A. N. Syzganov in Kazakhstan.

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Techniques for reducing surgical time of the lobectomy for lung cancer

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The Pulmonary Artery (PA) is the weakest vessel in the human body and it should never be grasped with forceps. We earlier described a technique for safe, rapid dissection of the PA and Pulmonary Vein (PV) that simply handles scissors in a novel way. Since 2001, this method has been applied in more than 1500 cases of segmentectomy, lobectomy and pneumonectomy during both open and video-assisted thoracic surgery. It employs Mayo-type scissors for sharp dissection of the PA and PV. Sheaths on the surfaces of the central parts of the pulmonary vessels are dissected using scissors approximately 5 mm long. The vessel is then ligated with 2-0 silk at the same site. The surgeon directly grasps the blood vessel with vascular forceps just distal to the first ligation site and retracts it to the central side. The distal side of the blood vessel is exposed aggressively with Mayo-type scissors by dissecting the sheaths surrounding the vessel with the associated connective tissue including perivascular lymph nodes. These maneuvers are easy possible when using this novel handling of the scissors.

The procedure easily exposes about 2 cm of small vessels and >3 cm of larger vessels. It is useful in most circumstances, e.g., tumor invasion of an area surrounding a blood vessel or with a perivascular enlarged lymph node without direct invasion. Almost all right upper lobectomies (ND2a) are completed within 2 hours (small thoracotomy) to 2.5 hours (complete VATS). Surgery duration can be dramatically shortened when using this method. This technique and the new method for handling the scissors will be demonstrated in a video.

Biography

Sadanori Takeo has completed his PhD at the age of 32 years from Kyushu University in Immunological Sciences. He was one of the pioneers in Thoracic Surgery and VATS Surgery in Japan. He and his team were the first to report "Original Video-Assisted Thoracoscopic Extended Thymectomy for Thymoma". He later became the Chairman of the Department of Thoracic Surgery at National Hospital Organization Kyushu Medical Center. He has served on the editorial boards of many scientific journals and on the advisory panels of many academic and government institutions. He is a member of board of the many academic association and has published more than 100 papers in lung cancer and mediastinal tumor fields.

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Saving the transverse colon: New surgical procedure in case of extensive left colon surgery

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Introduction: After extensive surgery of the left colon for cancer, chronic inflammatory bowel disease or abdominal trauma, since it is not always possible to create a well-vascularized and tension free anastomosis between the transverse colon and the rectum, it is necessary to choose among three surgical procedures: a definitive transverse colostomy, in order to save large intestinal functions; an ileo-rectal anastomosis, when it is preferred to preserve continence; the Deloyers procedure which involves the removal of the transverse colon and the transposition of the right colon into the pelvis to create an anastomosis with the rectum.

Materials and Methods: A 63 years-old male patient, underwent videolaparoscopic surgery for an adenocarcinoma of the rectum. Due to the occurrence of ischemia in the splenic flexure, we decided to perform an extended left proctocolectomy with a transverse colostomy. One year later, the patient undergo to recanalization surgery. The new procedure consisted in restoring the intestinal continuity between the transverse colon and the rectal stump by transposition of the right colon and creation of three anastomosis. The first was a stapled side-to-side ileo-transverse anastomosis, the second was a dual-layer hand-sewn end-to-end transverse-cecum anastomosis and last one was a single-layer hand-sewn end-to-end right colo-rectal anastomosis. Finally, a temporary ileostomy was performed. After 6 months the patient obtained a definitive recanalization.

Results: After recanalization, the patient showed normal bowel movements (2-3 per day) and soiling. During two weeks after hospital discharge, he progressively restored continence. The patient reported a satisfactory improvement of quality of life.

Conclusion: Saving the transverse colon and the right colon means achieving not only continence but also a better degree of reabsorption of liquids and vitamin K and group B production in order to keep intestinal functions as similar as possible to the normal physiology, the disadvantage, represented by the need to create three anastomosis, is offset however by the benefits in terms of improving the quality of life: avoiding diarrhea, incontinence and post-operative urgency.

Biography

Marica Grasso is a PhD student at the University of Salerno, Italy. She completed her medical studies and specialization in General Surgery at the University of Naples "Federico II" and perfected her career as a Surgeon at the Tertiary Care Hospital "A. Cardarelli" in Naples. She works as a Professor for the National Reference Schools of the Italian Society of Surgery in Endocrine Surgery, Advanced Laparoscopic Surgery and Technological Innovation applied to Surgery. She has published in the fields of abdominal surgery and endocrine surgery in reputed International Journals and has attended as a discussant at numerous International Conferences.

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Thoracoscopic radiofrequency ablation of the pulmonary veins in treatment of the isolated atrial fibrillation. First experience in Kazakhstan

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The aim of the study was to evaluate the mid-term results of the thoracoscopic radiofrequency ablation of the pulmonary veins in treatment of the isolated atrial fibrillation.

Methods: Since May 2015 in National Scientific Center of Surgery named after A.N. Syzganov, 25 patients with persistent and long-standing persistent atrial fibrillation underwent the thoracoscopic radiofrequency ablation of the pulmonary veins (Cardioblate Gemini-s iRF). The surgical procedure included ablation of the pulmonary veins, coagulation of the Marshall's ligament, cutting of left atrial appendage and performing of the epicardial mapping to estimate conduction block. Contraindications for procedure were: left atrial appendage thrombosis, adhesion in pericardial cavity (previous open heart surgery), an adhesive process in the pleural cavities (pneumonia, pleuritis), moderate or severe COPD.

There were totally 25 patients, 18 males and 7 females, the mean age was 59 years (33-74 years), 7 patients with persistent AF, 18 patients with long-standing persisting form of AF, the mean duration of AF was 4.2 years (3 months, 20 years), the mean size of the left atrium was 4.4 ± 0.9 cm, 10 patients were after catheter ablation, LV EF was 54% (36-67%), 6 patients had a mitral valve regurgitation of the 1-2 degree, mean LVEDV 165 (101-224) ml. In 21 patients cutting of left atrial appendage was performed using surgical stapler.

Postoperative amiodorone and warfarin were administered for 3 months. The efficacy of the treatment was estimated by means of cardiac monitor REVEAL XT, the mean follow-up time was 180 ± 19 days.

Results: All patients were on sinus rhythm after operation and at the time of discharge from hospital. One patient developed an atrial flutter (patient with cardiomyopathy, LV EF 36%) in 30 days after operation and radiofrequency ablation of the cavo-tricuspid isthmus was carried out, 2 patients developed atrial fibrillation in 1 and 6 months after surgical operation. There were no complications in postoperative period. During the follow up period 92% of patients were on sinus rhythm.

Conclusion: Thoracoscopic radiofrequency ablation of the pulmonary veins is a safe and effective method of a treatment of atrial fibrillation, especially in patients with large left atrium and ineffective previous catheter ablation.

Biography

Koshkinbayev Zhenis is a Cardiac Surgeon of Cardiac Surgery department at the National Scientific Center of Surgery named after A. N. Syzganov in Kazakhstan.

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