



Fig. 1 – Massive abdominal apron.

patients undergo post-bariatric panniculus resection after their body mass index (BMI) normalizes. But when the abdominal apron is so large that it limits daily activity, abdominal panniculectomy is proposed. Although the patients are explained how this procedure entails a high incidence of complications and even death, most patients choose to assume the risk. The operation must be carefully planned, and a device must be prepared in the operating room to raise the abdominal apron and suspend it in order to dissect the fat without it continuously obstructing the surgical field.

We present the case of a morbidly obese 40-year-old male with a massive abdominal panniculus (BMI: 61.73 kg/m²) that reached his ankles (Fig. 1).

In July 2017, he came to the Emergency Department for a fever of 38 °C, associated with foul-smelling suppuration from a wound secondary to distal necrosis of the abdominal apron. Lab work showed: 46.04 thousand/mm³ leukocytes, 86.2% neutrophilia, coagulopathy and lactic acid 4.9 mmol/L. Because it was technically impossible to perform an urgent standard computed tomography (CT) scan due to grade IV morbid obesity, the imaging test was performed in the inverted position (feet first) in order to visualize the content of the apron. He presented extensive cellulitis and an abscess measuring 25 × 13 cm in the most distal part; the presence of an inguinoscrotal hernia was ruled out. The patient underwent emergency surgery under general anesthesia to drain the abscess. Due to the state of septic shock caused by cellulitis of the apron, 48 h later we performed urgent abdominal dermolipectomy. To facilitate the surgical technique, a crane was used to suspend the panniculus by means of a 4-suture Ventrofil® (BRAUN) system, with 2 sutures through the skin at each end of the apron that were attached to both arms of the crane (Fig. 2).

The surgical specimen weighed 24 kg, and the patient required admission to the Resuscitation Unit for a week. After being discharged to the ward, he presented good evolution with targeted antibiotic therapy for *Actinomyces turicensis*, *Phorfyomonas somarae* and *Pseudomona aeruginosa*, which had been identified in cultures. PREVENA™ KCI negative pressure



Fig. 2 – Ventrofil® 4-suture system attached to the crane to suspend the panniculus.

therapy was placed over the surgical wound for 10 days to promote healing. Drain tubes were removed on the 7th and 11th days after surgery, and the patient was discharged one month after admission.

In November 2018, the patient returned to the Emergency Department for incarcerated umbilical hernia with no signs of intestinal obstruction, requiring urgent umbilical hernia repair. The patient had gained weight and once again presented a massive panniculus. On the 7th seventh post-operative day, he started a low-grade fever associated with cellulitis in the most distal region of the abdominal apron. Imaging tests ruled out associated abscess and, after the failure of conservative treatment using broad-spectrum antibiotic therapy, we decided to perform another dermolipec-

tomy, with the same suspension technique described; this time, the surgical specimen weighed 20.6 kg.

Several methods have been described to retract the abdominal apron during scheduled surgery. Ollapallil et al.² describe a technique with 2 Kuntcher nails that pierce the adipose pad and suspend it from a crane with chains. Gabilondo et al.³ use a 'stirrup-nail' system suspended from pulleys previously installed from the ceiling of the operating room. Graf et al.⁴ use a specific retractor: the Rultract Skyhook Surgical Retractor System (Rultract Inc, Cleveland, Ohio). Meanwhile, Fadel et al.⁵ use forceps that are connected to the abdomen with a bar that is lifted by a crane.

In our case, the panniculectomy was carried out urgently, and we had to use the resources available at that time, specifically the crane for obese patients and the Ventrofil® sutures through the skin on both sides of the panniculus, which were fastened to the crane arms to lift and move it. We believe that the suspension method we describe can be used in any hospital. It is effective because it holds the weight well, without tearing the skin, and provides good mobilization of the abdominal apron.

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Leiomyosarcoma of the right gonadal vein[☆]

Leiomiosarcoma de vena gonadal derecha



Primary leiomyosarcoma (LMS) of vascular origin is a rare tumor (1/100 000 malignant tumors) most frequently located in the inferior vena cava (60%).¹⁻⁴ Primary LMS of the gonadal vein is a very rare entity, and only a dozen cases have been reported in the literature.^{2,5,6}

A 72-year-old woman consulted for pain in the right flank, accompanied by early satiety and weight loss. Physical examination revealed a palpable mass in the right hemiabdomen that was painful to pressure.

Abdominal ultrasound detected a heterogeneous retroperitoneal mass measuring 6 × 5 cm and the presence of calcifications adjacent to the right renal pelvis, causing ipsilateral hydronephrosis. On computed tomography (CT) scan, this mass appeared to be in contact with the 2nd part of the duodenum and the inferior vena cava, with no clear signs

of invasion (Fig. 1). In addition, grade III right hydronephrosis was observed due to compression versus invasion of the middle ureter, along with calcifications and foci of intratumoral necrosis that could have been related to a GIST. Endoscopic ultrasound ruled out duodenal wall dependence/invasion. The results of ultrasound-guided CNB identified a malignant mesenchymal neoplasm with smooth muscle differentiation, indicative of LMS, although without being able to rule out WT-GIST. No secondary pulmonary deposits were found on extension chest CT.

With a diagnosis of retroperitoneal mesenchymal tumor, and with the uncertainty of being able to guarantee *en bloc* resection with negative margins via laparoscopy due to possible invasion of surrounding structures, an open approach was chosen. Using midline laparotomy, we found a mass

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