and need the conventional treatment. The concept of Quality of Life (QOL) in the Health area has a multidimensional approach and is related to the economic, social and cultural aspects, psychological and physical. The measurement of health-related QOL issues makes it possible to obtain standardized information about a patient's perception of the specific disease and its impact on his or her life. Then, the best practical daily practice in the health service can be guided, leading in consideration QOL as a pointer in the clinical judgment of specific illnesses.

Objectives: The goal of this study was to evaluate the health-related Quality of Life improvement of patients underwent laparoscopic or open cholecystectomy.

Methods: Sixty four consecutive patients from Department of Surgery of Santa Casa of São Paulo who underwent on cholecystectomy for nonmalignant disease were asked to fill a health survey's QOL questionnaire – the SF-36 – before and after the procedure. Nonparametric tests (Wilcoxon Sign Rank Test) were use when some variables did not confirm to a normal distribution. They were significant at $P < 0.05$ with statistical analyses performed by SigmaStat® for Windows, version 3.5.

Results: The all eight outcome scales within the SF-36 health profile from Functional status (Physical functioning, Social functioning, Role limitations attributed to physical problems, Role limitations attributed to emotional problems), Wellbeing (Mental health, Energy and fatigue, Pain) until Overall evaluation of health (General health perception) were found significant improvement ($P < 0.001$).

Conclusion: The clinical improvement observed on patients was evaluated and confirmed by statistics, so that cholecystectomy influences patient's life for the better, independently the access way, bringing benefits to those ones with impact on their QOL.

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INTRAOPERATIVE ENDOSCOPIC SPHINCTEROTOMY USING RENDEZVOUS TECHNIQUE FOR THE CASE WITH DIFFICULTY IN CANNULATING INTO COMMON BILE DUCT

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Endoscopic sphincterotomy (EST) is widely accepted as the sequential treatment of cholecystocholedocholithiasis before or after laparoscopic cholecystectomy (LC). EST is very important management for common bile duct (CBD) stones, but unfortunately there are some cases could not be undergoing EST because of failure of selective CBD cannulation. We report the single-step procedure, without choledocholithotomy, what is called rendezvous technique for these cases. This procedure is defined as EST after intraoperative cholangiography during LC using guidewire insertion through the transcystic route. We report a 62-year-old woman with CBD stone, and she is often suffering from CBD stone attack, but twice attempt of selective CBD cannulation under endoscopic retrograde cholangiopancreatography (ERCP) was failed. She was underwent intraoperative EST using rendezvous technique, and ERBD tube was positioned in the CBD. Rendezvous technique is the reliable strategy for the patients with cholecystocholedocholithiasis failed selective CBD cannulation under ERCP. Intraoperative endoscopic approach for papilla Vater is very difficult because the patient is spine position; therefore excellent endoscopists are absolutely needed to perform this procedure.

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POST CHOLECYSTECTOMY MIRIZZI SYNDROME: AN IMPORTANT RARE CASE REPORT-COMPLICATION

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Background: Mirizzi syndrome was first described in 1948 for uncommon cases of extrahepatic biliary strictures, with cholelithiasis which occurs in less than 0.5% of cholecystectomies. Extrahepatic, hepatic or common bile duct, obstruction may occur either of impacted stone in the cystic duct that cause direct pressure or edema (Mirizzi type I), or occasionally the stone may erode and delivered through the wall of cystic duct and into the common hepatic duct (Mirizzi type II).

Case report: We present a case of a 45-year-old woman who was admitted in our Department on July 2009, with symptoms of obstructive jaundice and cholangitis. From her past history, the patient referred a laparoscopic cholecystectomy three months ago. Following the research study an ERCP sphincterotomy was performed and the revealed biliary stenosis was stented by a seven French plastic tube. Because of the unsuccessful result of bile duct stent drainage an explorative laparotomy was planed. There were rare and interesting operative findings, such as a common hepatic duct (CHD) stenosis due to a choloma, just closely to the cystic duct stump which resulted in a severe degree of extra-ductal pressure and hepatic duct stenosis; the central tip of ERCP plastic tube was found intraperitoneally probably by CHD perforation, during previous ERCP sphincterotomy, in the location of this stenosis of common hepatic duct (CHD). An anatomic recognition and preparation of proximal biliary tract, was performed in porta hepatis, which was followed by a high hepaticoduodenostomy procedure. The postoperative period and the up- to- date follow-up is uneventful and no complications were observed so far.

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SURGICAL TREATMENT OF INTRAHEPATIC CHOLELITHIASIS: REPORT OF SIX CASES

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Introduction: Intrahepatic cholelithiasis is a rare entity, providing challenges in its diagnosis and treatment. Therapeutic goals include the elimination of cholangitis

episodes and the interruption of the progression of the disease that can lead to biliary cirrhosis and the development of cholangiocarcinoma.
Goal: To present the surgical treatment of six cases of intrahepatic cholelithiasis.
Methods: Four of the patients had previous cholecystectomy, one with a common bile duct exploration and placement of a Kehr, one with a choledochoduodenal anastomosis, and one with a choledochojejunal anastomosis. For the purposes of diagnosis a combination of US together with CT, MRCP and ERCP were used. In five patients the intrahepatic stones were localized centrally in relation to the left hepatic duct and in one of them there were also stones in the common bile duct. In the patient with the previous choledochoduodenostomy, there were biliary stones in the common and both hepatic bile ducts. In five of the cases there was atrophy of the left lobe with hypertrophy of the right one. In these cases the patients underwent a left hepatectomy, whereas in the case of the bilobar disease clearance of both hepatic ducts and a Roux-en-Y hepaticojejunostomy took place.
Results: Long-term follow-up of these patients revealed the effectiveness of hepatectomy as a therapy for unilobar intrahepatic cholelithiasis, as this deals with the cause of the stones as well.

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SINGLE INCISION MULTIPORT LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction: Although single incision multiport laparoscopic surgery has recently been the focus of minimally invasive surgery, the surgical techniques and indications for this procedure have not been established in many clinical practices. Herein, we report on our initial experience with 54 patients, who underwent single incision multiport laparoscopic cholecystectomy, together with their clinical outcomes and we determined the learning curve based on our experience.
Method: The data from 54 patients who underwent single-incision multiport laparoscopic cholecystectomy for gallstones and gallbladder polyps between January and June 2009 were documented prospectively and then analyzed. Four surgeons performed this procedure. We excluded the patients with acute cholecystitis, concomitant choledocholithiasis, a history of previous upper abdominal surgery, or a suspicion of gallbladder cancer. We calculated the learning curve with using OLS learning curve model.
Results: The mean age of the patients was 45.1 years. The mean body mass index (BMI) was 23.5 kg/m^2 (range: 15.68–30.09). Forty patients were symptomatic. The mean hospital stay was 4.5 days. The mean operative time was 91.2 ($\pm$ 32.0) min. In the analysis of operative time in OLS learning curve model, we could reach the operation time 68.5 min after performing 7.74 cases. Bile duct injuries occurred in two patients.
Conclusion: Single incision multiport laparoscopic cholecystectomy is an emerging operative method for obtaining a scarless abdomen. Experienced laparoscopic surgeons can safely perform this operation with the conventional and curved laparoscopic instruments and overcome the learning curve effect. Keeping an open mind for conversion to conventional laparoscopic cholecystectomy and assigning a priority to the safety of patients over cosmesis will help avoid serious complications when surgeons encounter difficulties during this type of operation.

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MINI-LAP CHOLECYSTECTOMY: AN ALTERNATIVE MINIMALLY INVASIVE SURGICAL PROCEDURE

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Background: Minimally invasive surgical procedures reduce the cost and the length of postoperative hospital stay. Procedures such as mini-lap cholecystectomy provide cost advantages, safe performance of procedure, rapid and early mobilization and decreased postoperative morbidity, especially in elderly, either laparoscopic or mini lap open access.
Patients and methods: We present a study of 128 consecutive mini laparotomies for cholecystectomy for symptomatic gallstones disease through a subcostal 5–7 cm incision during the last 15 years (1994–2008) in 1st Propedeutic Surgical Department of A.U. Th., A.H.E.P.A. Hospital. The mean operative time was 50 min (40–75 min). Mean postoperative analgesia requirements were four doses of non-narcotic analgesics. Mean duration of hospitalization was 36 hours (24–76 hours).
Results: Non severe complications were recorded and the 'overall' patient satisfaction was excellent in relation to postoperative pain, early recovery, cosmetic result, hospital stay and cost effectiveness.
Conclusion: We can conclude that surgeons experience, patient's history data, correct diagnosis and preoperative research study are the most important parameters for the final decision about the surgical technique of cholecystectomy.

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LONG-TERM SURVIVAL AND FIBROSIS PROGRESSION ANALYSIS IN RETRANSPLANTED PATIENTS FOR HCV RECURRENCE

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Body: Patients with positive HCV-RNA prior to liver transplantation (LT) have post-LT recurrence and the

