Israeli Pediatric Surgery Association and Pediatric Section of Urology Association

Summer Meeting

30.06 - 02.07.2016

Nahsholim, Sea Side Resort

ההסתדרות הרפואית בישראל

האיגוד הישראלי לכירורגית ילדים
והחוג לאורולוגית ילדים באיגוד האורולוגים הישראלי

ד"ר יחיאל שויד - יו"ר
פרופ' איגור סוחוטניק- מזכיר
ד"ר דרגן קרברושיץ- גזבר
ד"ר צבי שטיינר- חבר

ד"ר עמוס נאמן - יו"ר

Israeli Pediatric Surgery Association and Pediatric Section of Urology Association

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June 30, Thursday

15.00-17:00 **Accommodation**

17:00-17:30 **Registration**

17:30-17:45 **Opening Remarks: Yechiel Sweed, MD**

Session 1

Chairmen: Yuval Bar-Yosef; Ran Steinberg

17:45-18:15 **Management of Vesicoureteral Reflux: Current Status**

Prem Puri
National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

18:15-19:00 **A Professional Lifetime with the Foregut and the Hindgut: Redo Esophageal and Rectal Surgery**

Arnold G Coran
Emeritus Professor of Surgery
Section of Pediatric Surgery C.S. Mott Children's Hospital and University of Michigan Medical School, Ann Arbor, MI, USA

Dinner **19.00-20.30**

Social Program 20:30

July 1, Friday

Session 1

Chairs: Boris Chertin; Amos Vromen

8:30- 9:00 **Malignant Testicular Tumors: New Therapeutic Approaches**

Myriam Weyl Ben Arush
The Joan and Sanford Weill Pediatric Hematology Oncology and Bone Marrow Transplantation Division, the Ruth Rappaport Children's Hospital, Rambam Health Care Campus, Technion Faculty of Medicine, Haifa, Israel

9:00-9:30 **Variant Hirschsprung's Disease**

Prem Puri
National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

9:30-10:00 Update in Fetal, Neonatal and Pediatric Radiology

Liat Ben-Sira
Tel Aviv Sourasky Medical Center, Tel Aviv University.

Shelly Shiran
Tel Aviv Sourasky Medical Center, Tel Aviv University.

10:00-10:10 Renal Trauma: Case Reports and Updates

Sarel Halahmi
Dept of Urology, Bnai Zion Medical Center, Technion Faculty of Medicine, Haifa

10:10-10:20 Angiographic Embolization in Abdominal Pediatric Trauma

Sweed Y, Singer-Jordan Y, Papura S, Yulevich A
Pediatric Surgery, Invasive Radiology, Galilee Medical Center

10.20-10.30 One-stage Laparoscopic Orchiopexy in the Treatment of Intraabdominal Testis

Boris Chertin, Stanislav Kocherov
Department of Pediatric Urology, Shaare Zedek Medical Center, Faculty of Medicine, Hebrew University, Jerusalem, Israel

10.30-10.40 Prenatal Hydronephrosis Do Not as a "Soft Marker" for Trisomy 21

Amos Neheman, Guy Verhovsky, Gabi Kaplan, Ron Maymon, Amnon Zissman
Departments of Urology and Obstetrics and Gynecology, Assaf Harofeh Medical Center, Zerifin, Tel Aviv University, Tel Aviv, Israel

10.40-10.50 **Laparoscopic Surgery of Urachal Anomalies: A Single-Center Experience.**

Aranovich I, Kandelis E, Sukhotnik I
Dept of Urology, Bnai Zion Medical Center, Haifa

10.50-11.00 **A Tailored Surgical Approach to the Palpable Undescended Testis**

Amos Neheman, Eyal Kord, Amnon Zisman, Zvi Steiner
Department of Pediatric Urology and Pediatric Surgery, Meir Medical Center and Assaf Harofeh Medical Center, Tel-Aviv University

11:00-11:30 **Coffee break**

Session 2

Chairs: Sarel Halahmi, Dragan Kravarusic

11.30-12.00 **Structural and Molecular Basis of Pulmonary Hypertension in Congenital Diaphragmatic Hernia**

Prem Puri
National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

12.00-12.10 **Minimal Access Surgery for Repair of Selected Congenital Diaphragmatic Hernias- Recommendation is Related to Location**

Dragan Kravarusic, Zahavi Cohen, Enrique Freud
Dept of Pediatric Surgery, Soroka University Medical Center, Ben Gurion University, Beer Sheva, Dept of Pediatric Surgery, Schneider Children's Medical Center of Israel, University of Tel Aviv, Israel

12.10-12.40 **Rhabdomyosarcoma of the Genitourinary Tract: New Approaches**

Myriam Weyl Ben Arush
The Joan and Sanford Weill Pediatric Hematology Oncology and Bone Marrow Transplantation Division, the Ruth Rappaport Children's Hospital,Rambam Health Care Campus, Technion Faculty of Medicine., Haifa, Israel.

12.40-12.50 **Minimally Invasive Approach for Treatment of Seminal Vesicle Cyst Associated with Ipsilateral Renal Agenisis**

E Kord, A Neheman, A Zisman, A Darawshe, N Dally, P Noh
Department of Pediatric Urology, Assaf Harofeh Medical Center and Meir Medical Center, Tel-Aviv University

12.50-13.30 **The Surgical Management of Ulcerative Colitis in Children**

Arnold G Coran
Emeritus Professor of Surgery

Section of Pediatric Surgery C.S. Mott Children's Hospital and University of Michigan Medical School, Ann Arbor, MI, USA

13.30-14.30 **Lunch**

16:30 **Social Program**

19.00-20.00 **Dinner**

20:30 **Social Program**

July 2, Saturday

Session 1

Chairs: Amos Neheman, Alon Yulevich

9.00-9.20 The Science of Tissue Expansion

Alex Margulis MD
Department of Plastic and Reconstructive Surgery, Hand Surgery and Burn Unit, Hadassah Medical Center

9.20-9.30 Current Management of Lipoblastoma

E.Seguier-Lipszyc[1], A. Baazov[1], S. Ash[2], E. Freud[1]

[1] Department of Pediatric Surgery, Schneider Children's Medical Center of Israel
[2] Department of Oncology, Schneider Children's Medical Center of Israel

9.30-10.00 How to Prepare a Manuscript for Publication

Prem Puri, MD
National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

10.00-10.10 Double Mucosal Flap For the reconstruct A Novel Surgical approach using the vaginal septal tissue

Amitai Lorber, Dvora Bauman, Katya Chapchay, Ofer Gofrit, Dov Pode1, Mordechai Duvdevani, Ezekiel H Landau, Guy Hidas
Departments of Urology, Gynecology, and Plastic Surgery, Hadassah Hebrew University Medical Center, Jerusalem, Israel

10.10-10.20 Education Program for Trauma Prevention in Pediatric Surgery

Ocampo S, Babiyonishev I, Faran S, Daquar F, Yulevich A, Sweed Y
Dept of Pediatric Surgery, Galilee Medical Center, Nahariya

10.20-10.30 Case study: Pediatric Trauma- Multi Organs Injury; Pathophysiology, Treatment, and the Effects of the Injury on the Patient & Family

Y. Dvori[1] , R. Madar[2]
Pediatric Surgery Department, Soroka Medical Center, Beer Sheva[1,2]
1Pediatric Surgery Department – Soroka University Medical Center, Ben Gurion University, Beer Sheva , Israel
2Pediatric Surgery Department – Schneider Children's Medical Center of Israel, University of Tel Aviv, Israel

10.30-10.40 Definition and Classification of Meatal Stenosis Severity in Children

Jacob Ben Chaim [1] Eial Meir[2], Ofer Gofrit[3], Dov Pode[3], Mordechai Duvdevani[3], Ezekiel H Landau[2] , Guy Hidas[2]

[1] Pediatric Urology, Dana-Dwek Children's Hospital, Tel-Aviv Medical Center, Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel
[2] Pediatric Urology Unit, [3] Department of Urology, Hadassah Hebrew University Medical Center, Jerusalem, Israel

10.40-10.50 Use of the "Bogota Bag" for Temporary Abdominal Closure in Pediatric Patients: A 15-year Retrospective Study

N. Heimam, M. Newman, E.Neeman, I. Lazar
Dept Pediatric Surgery, Soroka University Medical Center, Ben Gurion University, Beer Sheva

10.50-11.00 Redo Vaginal Reconstruction using Buccal Mucosa: Initial Experience

Guy Hidas[1] , Ofer Gofrit[2], Dov Pode[2], Mordechai Duvdevani[2], Ezekiel H Landau1
Pediatric Urology Unit1, Department of Urology2, Hadassah Hebrew University Medical Center, Jerusalem, Israel

11.00-11.10 Pilonidal Sinus Disease: Time for Reevaluation of a Problem: from the …rear

Efrati Y, Klin B, Yardeni D
Dept Pediatric Surgery , Assaf Harofeh Medical Center, of Israel, University of Tel Aviv, Israel

11.10-11.20 Pediatric Lower Urinary Tract Questionnaire: Validation of the Hebrew Version

Guy Hidas[1], Ezekiel H Landau[1], Hava Gadassi[3], Jacob Ben Chaim [5], Ofer Gofrit[2], Dov Pode[2], Mordechai Duvdevani[2], Yaffa ZiskRani[4]

Pediatric Urology Unit1, Department of Urology2, Department of Pediatric3, and Nursing School4, Hadassah Hebrew University Medical Center, Jerusalem, Israel
5Pediatric Urology, Dana-Dwek Children's Hospital, Tel-Aviv Medical Center, Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel

11.20-11.30 Point-of-care ultrasound in a Department of Pediatric Surgery

Avinadav E, Almog A, Kravarusik D, Seguier E, Samuk I, Nika A, Freud N.
Department of Pediatric surgery, Schneider's Children Medical Center, Petah-Tikva, Israel

Closing Remarks

Prem Puri, MD

National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

Professor Prem Puri is the Newman Clinical Research Professor at the UCD School of Medicine and Medical Science, and President of the National Children's Research Centre at Our Lady's Children's Hospital. He is currently President of the World Federation of Associations of Paediatric Surgeons (WOFAPS) FOUNDATION, and Past President of the World Federation of Associations of Pediatric Surgeons (WOFAPS), and Past President of the European Paediatric Surgeons Association (EUPSA). He is Editor-in-Chief of Paediatric Surgery International, and also on the Editorial Board of several other journals. He is a member of the Health Research Board of Ireland. Prof. Puri is Honorary Fellow of a number of prestigious medical and scientific societies, including the American Surgical Association (ASA), American Academy of Paediatrics, American Paediatric Surgical Association, Japanese Association of Paediatric Surgeons, and also Argentinean, Austrian, Canadian, Czech, Croatian, Cuban, Indian and South African and Ukranian paediatric surgical associations.

Prof. Puri is known internationally for his research into underlying mechanisms causing birth defects, and innovative treatments, which have benefited children all over the world. He is a multi award-winning researcher whose previous awards include People of the Years Award in Ireland and the prestigious Denis Browne Gold Medal by the British Association of Paediatric Surgeons for outstanding contribution to paediatric surgery. He has been a visiting professor to many leading universities all over the world, and invited speaker to numerous international scientific meetings. He has published 10 books, 127 chapters in textbooks and over 500 articles in peer-reviewed journals.

Arnold G Coran

Emeritus Professor of Surgery
Section of Pediatric Surgery C.S. Mott Children's Hospital and
University of Michigan Medical School, Ann Arbor, MI, USA

Arnold G. Coran graduated from Harvard College in 1959 and Harvard Medical School in 1963. His training in general and thoracic surgery was done at the Peter Bent Brigham Hospital, and in pediatric surgery at the Children's Hospital Medical Center, in Boston. In 1969, he was the recipient of the Harvard Traveling Fellowship, which he used to study neonatal metabolism at the University of Oslo, in Norway. He spent the next two years at the Naval Medical Research Institute in Bethesda. In 1972, he was appointed Head of Pediatric Surgery at the Los Angeles County/UCS Medical Center and Assistant/Associate Professor of Surgery at the medical school there. In 1974, he became the Head of the Section of Pediatric Surgery and Professor of Surgery at the University of Michigan Medical School. In 1981, he became the Surgeon-in-Chief of the C.S. Mott Children's Hospital. In 1986, he established the pediatric surgery residency at the C.S. Mott Children's Hospital/University of Michigan Medical School.

Dr. Coran is a member of numerous national and international organizations, including the American Pediatric Surgical Association, American Surgical Association and the Society of University Surgeons. He is the past Chairman of the Surgical Advisory Council for Pediatric Surgery of the American College of Surgeons and is the past Chairman of the Executive Committee of the Surgical Section of the American Academy of Pediatrics. He has been the Chairman of the Surgical Advisory Panel of the American Academy of Pediatrics. He is the past President of the American Pediatric Surgical Association. Dr. Coran has served on the Overseas Council of the British Association of Pediatric Surgeons (BAPS). Dr. Coran is the recipient of the Salzberg Award from the American Academy of Pediatrics in 2007, the Denis Brown Gold Medal Award from the British Association of Pediatric Surgeons in 2007, the Swenson Medal and the Soave Medal. A list of Dr. Coran's publications is available.

Dr. Coran has contributed extensively in the various fields of Pediatric Surgery, including Parenteral and Enteral Nutrition, Shock in Children, Bacterial Translocation in the Neonate, and Extracorporeal Membrane Oxygenation in Pediatric Respiratory Failure. Among his clinical research efforts are studies concerning total body water and extra cellular fluid changes in infants receiving total parenteral nutrition and neonatal respiratory failure, esophageal surgery in infants and children, Hirschsprung Disease and Inflammatory Bowel Disease. Additionally, Dr. Coran has influenced his field through educational activities. He is the past President of the Association of Pediatric Surgery Training Program Directors; past Senior Advisor of the Surgical Section of the Children's Cancer Study Group; and a Founding Member of the Society for Pediatric Trauma. He is also a frequent Invited Lecturer and Visiting Professor throughout the world.

Myriam Ben Arush Clinical Professor

Director, Pediatric Division, Ruth Rappaport Children's Hospital
Director, Pediatric Hematology & Oncology

Professor Myriam Weyl Ben Arush, M.D., former Chair of the Israel Society of Pediatric Hematology Oncology and an internationally recognized expert in pediatric oncology, is the Director of the Pediatric Hematology-Oncology and Bone Marrow Transplantation Division and Deputy Director of Ruth Rappaport Children's Hospital. Prof. Ben Arush received the Ministry of Health's Prize for Outstanding Work and the Chevalier de la Legion d'Honneur in France. She was named one of the most caring physicians in the world by the World Medical Association for her exceptionally insightful and empathetic voice in professional discussions of the ethical, psychosocial, and quality of life aspects of pediatric cancer care.

She is also a Professor in Pediatric Hematology Oncology at the Rappaport Faculty of Medicine at the Technion - Israel Institute of Technology. Prof. Ben Arush has actively participated in a wide range of clinical and basic research projects and initiatives in pediatric oncology. Her main research interests are in diagnosis and management of solid tumors. She is the national principal investigator in rhabdomyosarcoma and an international member of the children's oncology group in the USA and other European organizations. Prof. Ben Arush has published about 150 articles in international journals. She is Associate Editor of the Journal of Pediatric Hematology Oncology and editor of a book on psychosocial aspects in pediatric oncology.

Liat Ben-Sira Clinical Professor

Head Pediatric Radiology Division
Dana Children's Hospital
Tel Aviv Sourasky Medical Center

Director of Pediatric Radiology Division at Dana Children's hospital since 1999. Dean's list for outstanding Medical student at Hadassah School of Medicine, Jerusalem. After completion of Radiology residency in Hadassah and two-year residency of Pediatrics in Schneider Children's Medical Center TAU, spent two and a half years at Harvard University School of Medicine, Children's Hospital specializing in Pediatric Radiology.

In the last 15 years, performed above 4,000 fetal MRI developing and providing clinical guidance for multiple OBGYN centers throughout the country. Actively participated in the diagnosis and management of complicated pregnancies, specializing in fetal CNS anomalies. Main research projects include malformations of fetal development, Neurofibromatosis and tumor follow-up, Pediatric Neurosurgery and Advanced Imaging in MRI of normal CNS development.

Published above 100 articles and participates in multiple national and international conferences.

June 30, Thursday

Session 1 *17:45-19:00*

Management of Vesicoureteral Reflux: Current Status

Prem Puri

National Children's Research Centre, Dublin
School of Medicine and Medical Science and Conway Institute of Biomolecular and Biomedical Research, University College Dublin, Dublin, Ireland

Primary Vesicoureteral Reflux (VUR) is the most common congenital urological abnormality in children, occurring in 1-2% of pediatric population and in 30-40% of children presenting with a urinary tract infection (UTI). The association of VUR, febrile UTI and renal parenchymal damage is well recognised and reflux nephropathy is a major cause of childhood hypertension and chronic renal failure. The various treatment options currently available in the management of VUR are: (1) Long-term antibiotic prophylaxis; (2) Open Surgical Treatment; (3) Observation or intermittent therapy with management of bladder/bowel dysfunction and treatment of UTI as they occur; (4) Minimally Invasive Endoscopic Treatment.

This lecture is intended to provide paediatric surgeons and paediatric urologist our current understanding and treatment of VUR as well as future opportunities in the management of the child with VUR.

A Professional Lifetime with the Foregut and the Hindgut: Redo Esophageal and Rectal Surgery

PROF ARNIE CORAN

This lecture will present a lifetime experience with redo esophageal surgery involving repairs of recurrent tracheoesophageal fistulas and other redo operations following unsuccessful initial repair of esophageal atresia and tracheoesophageal fistula. My experience with these problems includes 57 recurrent tracheoesophageal fistula repairs, some of which involved 7 reoperations and 194 gastric transpositions done for various previous unsuccessful operations in children.

July 1, Friday

Session 1 8:30-11:30

MALIGNANT TESTICULAR TUMORS: NEW THERAPEUTIC APPROACHES.

Myriam Weyl Ben Arush, The Joan and Sanford Weill Pediatric Hematology Oncology and Bone Marrow Transplantation Division, the Ruth Rappaport Children's Hospital, Rambam Health Care Campus, Technion Faculty of Medicine., Haifa, Israel.

Testicular tumors account for 1-2% of all pediatric tumors, with an incidence of 0.05-2 per 100,000 children. A bimodal age distribution is observed; one peak occurs in the first 2 years of life, and the second occurs in young adulthood. Pediatric prepubertal testicular tumors are dramatically different from adult neoplasms. Germ-cell tumors account for only 60-77% of testicular tumors in children. Seminomas and mixed germ-cell tumors are Sertoli-cell tumors are the most common gonadal stromal tumors in prepubertal children extremely rare in prepubertal children. Leukemia and lymphoma are the most common secondary malignancies to affect the testis. These tumors can present bilaterally, and, because the blood-testis barrier protects the intratesticular cells, the testis may be the site of residual tumor in children after chemotherapy. Metastatic Rhabdomyosarcoma is the most common paratesticular malignant tumor (17%) and may arise from the distal spermatic cord and appear as a scrotal mass or hydrocele. These tumors have a bimodal distribution and occur in boys aged 3-4 months and in teenagers. Up to 70% of cases involve the retroperitoneal lymph nodes at presentation. The type of testicular tumor is diagnosed after inguinal orchiectomy or after an inguinal approach to testicular-sparing surgery is used.
The focus of the presentation will describe the therapeutic approaches in testicular germ cell tumors and paratesticular rhabdomyosarcoma, including the local treatment.

Variants of Hirschsprung's Disease

Prem Puri

National Children's Research Centre, Our Lady's Children's Hospital, Dublin
School of Medicine and Medical Science and Conway Institute of Biomedical Research, University College Dublin

Variants of Hirschsprung's disease (HD) are conditions that clinically resemble Hirschsprung's disease despite the presence of ganglion cells in rectal suction biopsies. The characterization and differentiation of various entities is mainly based on histological, immunohistochemical and electron microscopy findings of biopsies from patients with functional intestinal obstruction. Intestinal neuronal dysplasia (IND) is histologically characterized by hyperganglionosis, giant ganglia and ectopic ganglion cells. In the majority of IND cases conservative treatment such as laxatives and enema are sufficient. Some patients may require internal sphincter myectomy. Patients with the diagnosis of isolated hypoganglionosis (IH) show decreased numbers of nerve cells, decreased plexus area as well as increased distance between ganglia in rectal biopsies, and resection of the affected segment has been the treatment of choice. The diagnosis of internal anal sphincter achalasia (IASA) is based on abnormal rectal manometry findings whereas rectal suction biopsies display presence of ganglion cells as well as normal acetylcholinesterase (AChE) activity. IASA is either treated by internal sphincter myectomy or botulinumtoxin injection. Megacystis microcolon intestinal hypoperistalsis (MMIHS) is a rare condition and the most severe form of functional intestinal obstruction in the newborn. MMIHS is characterized by massive abdominal distension caused by a largely dilated non-obstructed bladder, microcolon and decreased or absent intestinal peristalsis. Although the outcome has improved in recent years, survivors have to be either maintained by total parenteral nutrition or have undergone multivisceral transplant. This lecture discusses the current management of the above mentioned entities of variant HD.

Update in Fetal, Neonatal and Pediatric Radiology

Liat Ben-Sira ,Shelly Shiran

Tel Aviv Sourasky Medical Center, Tel Aviv University.

The lecture will be dedicated to new and old “TRICKS” in MRI abdominal imaging from fetal to neonatal, and beyond.
Emphasis will be made on congenital complicated urogenital anomalies.

The lecture will also be dedicated to the post-natal MRI abdominal imaging.

ANGIOGRAPHIC EMBOLIZATION IN ABDOMINAL PEDIATRIC TRAUMA

Sweed Y, Singer-Jordan Y, Papura S, Yulevich A

Pediatric Surgery, Invasive Radiology, Galilee Medical Center

Aim: Angiography and embolization are well recognized as the primary treatments in certain cases of acute traumatic hemorrhage in adults. We present 4 pediatric trauma patients in which transcatheter arterial embolization (TAE) was performed in order to determine the efficacy of this treatment in children.

Methods: 3 children with blunt abdominal trauma and one child with iatrogenic renal injury (ages 4-13 years) were managed with TAE for lacerated liver (1 patient), pelvic fractures (1) and renal injuries (2 patients). The first two patients, victims of road accidents, had multisystem injuries and were treated by emergency embolization after fluid resuscitation in the Emergency Department (ED). The next 2 patients had renal injuries: a 4 - year- old boy with blunt abdominal trauma was diagnosed on initial CT with an unexpected Wilms tumor and was treated with embolization one day after admission due to hemodynamic deterioration caused by active arterial tumor bleeding. The following day he underwent successful nephrectomy. The other patient was 13- year-old boy with nephrotic syndrome underwent renal biopsy and developed hemodynamic instability. After fluid resuscitation, he underwent an initial negative angiography, but a second-look angiography the following day revealed an active bleeding from an aberrant renal artery, which was then successfully embolized.

Results: In all 4 patients presented, TAE was diagnostic as well as therapeutic, and no child required surgical intervention for control of bleeding.

Conclusions: We propose that emergency transcatheter angiography and arterial embolization should be considered following resuscitation in the ED, as initial treatment in children with ongoing bleeding after blunt abdominal trauma as well as iatrogenic renal injury.
Implementation of this policy demands availability and cooperation of the interventional radiology services.

One stage Laparoscopic Orchiopexy in the treatment of intraabdominal testis

Boris Chertin, Stanislav Kocherov

From the Department of Pediatric Urology, Shaare Zedek Medical Center, Faculty of Medicine, Hebrew University, Jerusalem, Israel

To date, laparoscopy has gradually become the gold standard for treatment of non-palpable testicles (NPT) with different success and complication rates. In this study, we aimed to evaluate outcomes of the one stage laparoscopic orchiopexy for NPT.

MATERIALS AND METHODS:
We reviewed data of all patients who underwent one stage laparoscopic treatment for unilateral and bilateral NPT at our institutions from January 2008 to December 2015. Age (at surgery), follow-up time, laterality of testes, and postoperative complications, testicular size and position at follow up were analyzed.

RESULTS:
36 consecutive patients with the median age of 16 months underwent One Stage Laparoscopic Orchiopexy.
6 patients (44.4%) had Peeping testis type, in 13 patients (36.1%) testicle was located within 2 cm from the internal ring and in the remaining 7 patients (19.4%) testicle was detected above 2 cm from the internal ring. In six children (16.7%) dividing the spermatic vessels was performed in one stage with Laparoscopic orchiopexy. In the remaining 30 patients (83.7%) laparoscopic one stage procedure was performed with the preservation of the spermatic vessels. Testicular atrophy was observed in 2 cases (5.6%), and 6 patients (16%) had relatively small testicle compared to the contralateral normal testicle at the follow up. 2 patients (5.6%) presented with testicle positioning in the entrance area into the scrotum. None of the patient demonstrated hernia recurrence at follow up. There was no difference in surgical outcome in children who had surgery while preserving the spermatic vessels versus those who underwent orchiopexy with dividing spermatic vessels in one stage.
CONCLUSIONS
Laparoscopic transection of the testicular vessels is appeared to be safe in boys with high abdominal testes that do not reach the scrotum after laparoscopic high retroperitoneal dissection. The magnification and wide mobilization of laparoscopy likely allow better preservation of the collateral vascular supply. The 1-stage procedure avoids repeat anesthesia and the extensive, sometimes tedious, dissection that is occasionally required during reoperation. There is no doubt that monitoring child into adolescence will give an answer about the long-term effectiveness of the technique.

Prenatal hydronephrosis do not perform well as a "soft marker" for trisomy 21

Amos Neheman[1] MD,Guy verhovsky MD[1] , Gabi Kaplan[2] MD, Ron Maymon[2] MD, Amnon Zissman1 MD,MHA[2]

- *The Urology Department, Assaf Harofeh Medical Center, Zerifin, Tel Aviv University, Tel Aviv, Israel*
- *Obstetrics and Gynecology Department, Assaf Harofeh Medical Center, Zerifin, Tel Aviv University, Tel Aviv, Israel*

PURPOSE:
To evaluate the association between trisomy 21 and prenatal hydronephrosis at second trimester ultrasonography in fetuses with trisomy 21.

METHODS:
Retrospective cross-sectional assessment of fetus with trisomy 21 diagnosed by fetal karyotype obtained by amniocentesis/cordocentesis, between January 1998 and April 2014.
Urinary tract abnormalities (UTA) where characterized according to morphological ultrasonography findings. Fetus with isolated UTA were compared to those with multiple systemic anomalies including UTA.

RESULTS:
There were 540 cases of trisomey 21. Isolated UTA in 13 cases (2.4%) and 21 cases (3.9%) with multiple fetal abnormalities. Overall UTA was recognized in 34 cases (6.3%). The main anomaly in both groups was bilateral mild pelviectasis (less than 5 mm.) and one case of posterior urethral valve. Only in the isolated UTA there was one case (2.9%) that both nuchal screening and triple test (1:470) where considered normal and trisomy 21 was primarily diagnosed by amniocentesis. In the rest of the trisomy 21 population without UTA (n=506) there were 11 such cases (2.2%, $p>0.05$).

CONCLUSION:
Prenatal diagnosis of UTA is known to be increased in fetus with trisomy 21 and is considered to be a "soft marker". Our data suggest that although the most common finding is bilateral pelviectasis, UTA do not perform as a fair marker for un diagnosed trisomy 21.

Laparoscopic surgery of urachal anomalies: a single-center experience

Aranovich I, Kandelis E, Halahmi S, Sukhotnik I

Dept of Pediatric Surgery and Urology, Bnai Zion Medical Center, Haifa

BACKGROUND: The traditional surgical approach to the excision of persistent urachal remnants is a lower midline laparotomy or semicircular infraumbilical incision. The aim of this study is to report our experience with laparoscopic/open urachus excision as a minimally invasive diagnostic and surgical technique.

METHODS: This study was a prospective study involving patients who were diagnosed with persistent urachus and underwent laparoscopic/open excision. The morbidity, recovery, and outcomes of surgery were reviewed.

RESULTS: Eight patients (M:F – 6:2) with an age of 1 month to 17 years underwent laparoscopic (6 patients) or open (2 patients) excision. All patients presented with discharge from the umbilicus. Although three patients had no sonographic evidence of a patent urachus, a diagnostic laparoscopy detected a patent urachus that was excised laparoscopically. The operative time of laparoscopic operation rinse between 19 to 71 minutes (last case was combined with bilateral laparoscopic inguinal hernia repair), and the mean duration of hospital stay was 1.3 ± 1.38 days. Pathological examination confirmed a benign urachal remnant in all cases.

CONCLUSION: Laparoscopy is a useful alternative for the management of persistent or infected urachus, especially when its presence is clinically suspected despite the lack of sonographic evidence. The procedure is associated with low morbidity, although a small risk of bladder injury exists, particularly in cases of severe active inflammation. Recurrence is uncommon and was caused by inadequate excision of inflammatory tissue in our series that was easily managed laparoscopically.

A Tailored Surgical Approach to the Palpable Undescended Testis

גישה ניתוחית מותאמת לקיבוע אשך תמיר נמוש

עמוס נאמן[1], אייל קורד[1], אמנון זיסמן[1], צבי שטיינר[2]

1 המחלקה לאורולוגיה,מרכז רפואי אסף הרופא המסונף לפקולטה לרפואה ע"ש סאקלר אוניברסיטת ת"א, צריפין
2 היחידה לכירורגיית ילדים, מרכז רפואי מאיר המסונף לפלוקטה לרפואה ע"ש סאקלר אוניברסיטת ת"א, כפר סבא.

מטרה
קיבוע של אשך תמיר יכול להתבצע בגישה מפשעתית (מסורתית) או בגישה סקרוטלית. קיבוע בגישה הסקרוטלית, למרות יתרונותיה הברורים (ירידה ברמת כאב לאחר ניתוח והתאוששות קצרה יותר) אינה נתמכת באופן מסורתי בשל חסרונות כגון גישה מוגבלת לאשכים מפשעתיים גבוהים ופתולוגיות מפשעתיות הנמצאות במקביל כמו בקע והידרוצלה. אנו מציגים את נסיוננו בגישה כירורגית מותאמת לקיבוע אשך תמיר המבוססת על ממצאים בבדיקה פיזיקלית.

שיטות
ניידות האשך בבדיקה פיזיקלית בהרדמה הובילה את הבחירה בגישה כירורגית מותאמת.במידה ונמוש אשך תמיר "נמוך" (הוגדר כאשך שניתן לנייד לסקרוטום) בוצע קיבוע בגישה סקרוטלית.במקרים של אשך תמיר "גבוה" (לא ניתן לנייד לסקרוטום) בוצע קיבוע בגישה מפשעתית.
הצלחת הניתוח הוגדרה ע"י מיקום וגודל האשך במעקב לאחר 3 חודשים מהניתוח.

תוצאות
סה"כ בוצעו 259 קיבועים לאשך תמיר ב181 ילדים. (78 מקרים של קיבוע דו"צ)
קיבוע בגישה סקרוטלית בוצע ב125 מקרים (48%) וקיבוע בגישה מפשעתית ב134 מקרים (52%). זמן הניתוח היה קצר באופן מובהק סטטיסטית בגישה הסקרוטלית.(25 דקות לעומת 40 דקות בגישה מפשעתית).
אחוז הצלחת הניתוח היה 98% ללא הבדל סטטיסטי בין הגישות. 3 ילדים שנותחו בגישה מפשעתית ו2 ילדים שנותחו בגישה סקרוטלית נזקקו לניתוח חוזר בשל אשך תמיר שהתמיד לאחר ניתוח.
אטרופיה של האשך המקובע נצפתה בתדירות גבוהה יותר בגישה המפשעתית (5/134) מאשר בגישה הסקרוטלית (0/125) ($P<0.05$). כמו כן נצפתה תדירות גבוהה יותר של אשך היפוטרופי בילדים שנותחו בגישה מפשעתית (17/134) לעומת הגישה הסקרוטלית (6/125) ($P<0.05$).

מסקנות
כחצי מהמקרים של אשך תמיר בקרוב הינם "נמוכים" וניתנים לניתוח בגישה סקרוטלית. לגישה ניתוחית מותאמת על פי הממצאים בבדיקה פיזיקלית יש יתרונות עם אחוז גבוה של הצלחה ניתוחית.

Session 2 11:30-13:30

Structural and Molecular Basis of Pulmonary Hypertension in Congenital Diaphragmatic Hernia

Prem Puri

The high morbidity and mortality in congenital diaphragmatic hernia is attributed to severe pulmonary hypoplasia and persistent pulmonary hypertension (PPH). Persistent pulmonary hypertension in characterized by the failure of pulmonary vasculature to remodel after birth and the vessels remain thick-walled. This lecture describes the Structural and Molecular Basis of Pulmonary Hypertension in Congenital Diaphragmatic Hernia.

Minimal access surgery for the repair of selected congenital diaphragmatic hernias
* recommendation is related to location *

Dragan Kravarusic[1] , Zahavi Cohen[1] and Enrique Freud[2]

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Background:
Congenital diaphragmatic hernias (CDH) may present early or later with either chronic or acute clinical manifestation. The aim of this presentation is to evaluate our experience with the use of minimal access surgery (MAS) for the repair of selected CDH.

Methods:
Retrospective review of 43 consecutive patients with CDH who underwent MAS repair over the last 10 years. Their weight ranged from 2.9 to 21 kg and ages from 2 days to 6 years. Sixteen were found incidentally during a chest x-ray, 15 presented with a sudden onset of dyspnea, and twelve had a history of intermittent vomiting.
Results:
Morgagni hernia was confirmed in 21 patients, all safely repaired with laparoscopic approach with minor modifications in operative technique.
Bochdalek diaphragmatic hernia found in 9 cases, initially two repaired by laparoscopic approach , one by combined that evolved to thoracoscopic approach for the repair in six patients. All done as primary repair , one recurrence in early post op – re do via laparotomy. One conversion to open for large defect – repaired with prosthetic mesh. In that case recurrence reported one year after surgery.
Hiatal/paraesophageal hernia – large sliding or rolling of stomach/bowel into chest cavity confirmed in 13 patients. Uneventful laparoscopic primary repair done in ten cases.
Stomach found displaced into thorax with difficult mobilization due to twist and adhesions in 3 cases. In one repair completed by laparoscopy , one case cornverted to open repair due to technical difficulties in visualization and one due to intraoperative complication - esophageal injury revealed during the surgery.
In 4 of 13 patients with rolling hiatal/paraesophageal hernia, anti-reflux procedure was performed as well. Follow-up chest radiograph demonstrated complete resolution in all cases. In MAS cases the average time to full diet was 36 hours, narcotics were given only in first 24 hours and median hospital stay was 3.4 days.

Conclusions: Recommendations for MAS approach in the repair of selected CDH are related to their location .

1- Anterior hernias - Morgagni Larrey - Laparoscopy is safe with excellent outcome.

2- Postero lateral - Bochdaleck - MAS should be reserved only for selected stable patients, mostly late presenting with minimal pulmonary hypertension with clearance & presence of skilled anesthesiologist. Preferable thoracoscopic *combine over laparoscopic approach.

3- Central - sliding , rolling paraesophageal / large hiatal hernias - MAS technique is accurate operative tool for great majority. In complex cases with organo-axial volvulus and multiple congenital adhesions final repair request safety consideration for conversion to open surgery.

MAS repair has rapid recovery and superior cosmetic results.

RHABDOMYOSARCOMA OF THE GENITOURINARY TRACT: NEW APPROACHES

Myriam Weyl Ben Arush,

The Joan and Sanford Weill Pediatric Hematology Oncology and Bone Marrow Transplantation Division, the Ruth Rappaport Children's Hospital, Rambam Health Care Campus, Technion Faculty of Medicine., Haifa, Israel.

Rhabdomyosarcoma (RMS) is the most common soft tissue sarcoma in children . In patients with localized disease, overall 5-year survival rates have improved to more than 80% with the combined use of surgery, radiation therapy, and chemotherapy. However, in patients with metastatic disease, little progress has been made in survival rates, with a 5-year, event-free survival rate of less than 30%. Genitourinary (GU) tract RMS is about 18% of all sites, , 73% are younger than 5 years. In patients with rhabdomyosarcoma of the GU tract without bladder or prostate involvement, 27% are older than 15 years. Treatment in patients with rhabdomyosarcoma (RMS) involves a combination of surgery, chemotherapy, and radiation therapy. The treatment of bladder and prostate rhabdomyosarcoma (B/P RMS) in children continues to develop away from radical cystectomy or prostatectomy to a combination of biopsy, chemotherapy, radiotherapy and/or surgical resection. The timing and method of local control continues to be controversial, as the side-effects of surgical excision or radiotherapy in the pelvis of the young child can have devastating effects on urinary continence and sexual function later in life. While the chemotherapy regimens for B/P RMS achieve good overall survival (OS) and event-free survival (EFS) rates, the ability to determine whether a residual mass that remains after chemotherapy and radiotherapy represents tumor remains a major problem. The role of the PET-CT will be discussed.

Studies focusing on decreasing chemotherapy dosing should focus on small B/P tumos, so that the minimal amount of chemotherapy necessary to achieve a complete response can be determined. For the large B/P tumors, they are known to be more aggressive, have worse EFS and OS, and require more local therapy to achieve a cure. From a surgical perspective, the ability to perform a partial cystectomy vs. a radical cystectomy is determined by the site where the tumor originates in the bladder, not the size of the tumor.

The addition of brachytherapy to surgery will be also discussed.

The Surgical Management of Ulcerative Colitis in Children

PROF ARNIE CORAN

This lecture will describe my experience with pull-throughs for Ulcerative Colitis in children. The lecture will describe the initial approach involving a straight endorectal pull-through and a later experience with the J-Pouch endorectal pull-through. Included in the talk will be a study reviewing a large number of children who underwent one of these two operations with a detailed analysis of the differences. Also, a short movie of a J-Pouch endorectal pull-through will be shown.

July 2, Saturday

Session 1 9:00-11:30

The Science of Tissue Expansion

Alex Margulis MD

The author present his experience with the design of expanded skin flaps gained over the past 15 years in a large series of 885 expanded flap reconstructions performed in 526 operations in 330 patients. The indications for tissue expansion were giant congenital pigmented nevi (72.7 percent), scar contractures (11.2 percent), and a remainder for a variety of congenital and acquired deformities. Surgical strategies were reviewed retrospectively to determine the location in the body where the tissue expansion was performed, the number of procedures required to accomplish the reconstructive goal, and the design of the expanded flap that was used to reconstruct the involved area. Specific points that were noticed included contour deformities (such as webbing, dog-ears, or decreased limb circumference) following flap reconstruction, anatomic distortions (such as distortion of the eyebrow or the distance from the brow to hairline) following reconstruction, final position of the scars in relation to anatomic landmarks, borders of aesthetic units, and relaxed skin tension lines, and the potential for later scar contracture.

Current Management of Lipoblastoma

E.Seguier-Lipszyc[1], A. Baazov[1], S. Ash[2], E. Freud[1]

[1] Department of Pediatric Surgery, Schneider Children's Medical Center of Israel
[2] Department of Oncology, Schneider Children's Medical Center of Israel

Lipoblastoma is a rare and benign tumor arising from embryonal fat, occurring in general in male children younger than 3 years of age, with a rapid growth rate. Most of these tumors are located in the extremities or trunk, other sites are rare but include the neck, scrotum, axilla, mediastinum and intraperitoneal. We present our series of 5 children treated at our institution from 2011 with lipoblastoma. Three boys and 2 girls with a median age of 2 years and 7 months underwent resection of a relative large mass in the axilla (2), inguinal region (1), perineal (1) and the omentum (1). The follow up goes from 1 to 3 years. One boy presented a local perineal recurrence and underwent a second resection two years after the first without further recurrence at one year. Three children underwent MRI before and as a follow up tool and all underwent US. The treatment of choice consists of complete surgical resection that needs to remain non radical. Higher awareness of this pathology from the pediatric surgeon enables an optimal resection and stresses the importance of a long follow up.

Double Mucosal Flap for Reconstruction of Transverse Vaginal Septum: a Novel Approach Using the Vaginal Septal Tissue

Amitai Lorber[2], Dvora Bauman[3], Katya Chapchay[4], Ofer Gofrit2, Dov Pode[2], Mordechai Duvdevani[2], Ezekiel H Landau[1], Guy Hidas[1]

Pediatric Urology Unit[1], Department of Urology[2], Gynecology[3], and Plastic Surgery[4], Hadassah Hebrew University Medical Center, Jerusalem, Israel

Congenital complete transverse vaginal septum requires definitive surgical correction. Its incision or resection followed by primary end-to-end anastomosis of the lower and upper vagina mucosa is a common practice. Furthermore, low transverse vaginal septum might be confused with imperforated hymen, and therefore, managed by simple resection and circular closure. The major drawback of this technique is scar formation followed by contracture shortening and narrowing the vagina. Subsequently, severe vaginal stricture or obliteration may result in hematocolpus, dyspareunia, and major vaginal trauma during labor. Repeat vaginal reconstruction often required. The risk for those complication increases with increasing thickness of the septum.

We describe a novel technique to reconstruct a vagina obliterated with transverse septum. The principle of this technique is the use of the septal tissue itself to overcome the missing vaginal tissue, thus increasing vaginal circumference. We believe that this technique reduces the risk of vaginal stenosis and shortening.

EDUCATIONAL PROGRAM FOR TRAUMA PREVENTION IN DEPARTMENT OF PEDIATRIC SURGERY

Ocampo S, Babiyonishev I, Faran S, Daquar F, Yulevich A, Sweed Y

Pediatric Surgery, Galilee Medical Center

Unintentional injury is the leading cause of morbidity and mortality in children age 1-17 years in Israel.Of 190,000 children who arrive to the emergency room each year, 23,500 are hospitalized and 117 children die because of unintentional injury. The home is the most common place where injuries occur.

It was found that the right time to increase the knowledge of parents and the family regarding trauma prevention is while the child is in hospital.

A special program for the security of the child was developed by "be-terrem" organization together with the Ministry of Health and since 2003 many hospitals have implemented this program in order to decrease the rate of childhood injuries at home and in road accidents.

The program is based on the research that showed a strong correlation between an injury to a child and a second injury to the same child or any other member of his family as a result of behavior failure. 10% of the children who arrive to the emergency room, or their siblings, will arrive to the hospital once again during the same year.

Our Department of Pediatric Surgery joined this program of trauma prevention in 2012. All the nurses of the medical staff as well as the educational staff take part in this program.

Twice a week the medical and the educational staff meet the parents and their injured children in the department's classroom, and each parent tells the others how his child was injured. The instructor (the teacher or the nurse) leads a discussion regarding the case, which enables all the participants to learn from the experience of others in order to be more aware of caring for their children, in order to prevent trauma again.

The best way to deal with trauma is to prevent it!

Case study:
Pediatric Trauma- Multi Organs Injury; Pathophysiology, Treatment, and the Effects of the Injury on the Patient & Family

Y. Dvori[1], R. Madar[2]

Pediatric Surgery Department, Soroka Medical Center, Beer Sheva[1],[2]

Patients after a serious car accident, arriving the emergency room, with a multi organs injuries, including internal injuries to the chest and abdomen, bone fractures, head injuries and urinary tract injuries. 90% of the casualties with abdominal trauma are due to car accidents. During the trauma to the abdomen, if the bladder is distended or the pelvis is fractured, the normal protective influence of the pelvic is lost and the shearing force of the pelvic fracture may tear the bladder. In fact, every extraperitoneal bladder rupture due to blunt trauma is associated with pelvis fractures.

Other aspect to address with a patient after a car accident is head trauma.

Diffuse axonal injury is a spectrum of abnormalities, from primary mechanical breaking of the axonal cytoskeleton, through a secondary physiological changes depending on the severity and extent of injury these changes can manifest as immediate loss of consciousness or confusion, and persist as coma and/or cognitive dysfunction.

Physical, cognitive, emotional and behavioral changes can be presen years after the accident. These outcomes may be influenced by family factors including socioeconomic status, family functioning and psychological stressors.

Rehabilitative goals are set during hospitalization and re-evaluated throughout the recovery. The long-term goal is to maximize the child's independent functioning and cognitive abilities.

Definition and Classification of Meatal Stenosis Severity in Children

Jacob Ben Chaim [1] Eial Meir[2], Ofer Gofrit[3], Dov Pode[3], Mordechai Duvdevani[3], Ezekiel H Landau[2] , Guy Hidas[2]

Pediatric Urology, Dana-Dwek Children's Hospital, Tel-Aviv Medical Center, Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel
Pediatric Urology Unit[2], Department of Urology[3], Hadassah Hebrew University Medical Center, Jerusalem, Israel

תיקוף הגדרה ודירוג חומרת היצרות פיית השופכה בילדים

גיא הידש[1], יעקב בן חיים[2] , איתי מאיר[1], דב פודה[1], עפר גפרית[1], מרדכי דובדבני[1], יחזקאל לנדאו[1]

1 היחידה לאורולוגית ילדים והמחלקה לאורולוגיה, המרכז הרפואי של הדסה והאוניברסיטה העברית, ירושלים,
2 בית החולים דנה לילדים המרכז הרפואי תל אביב (איכילוב)

היצרות בפיית השופכה היא בעיה נפוצה בקרב בנים נימולים ושכיחותה מגיעה עד 10%-5% מהאוכלוסיה. הביטוי הנפוץ של התופעה הוא בזרם שתן דק וחזק המופנה כלפי מעלה או הצידה. אין קריטריונים ברורים להגדרתה ולהגדרת חומרתה של ההיצרות והאבחנה מתבצעת כיום באמצעות בדיקה פיזיקלית שכוללת הסתכלות על פיית השופכה ולקיחת אנמנזה.
מטרת המחקר:- לפתח שיטת דירוג אחידה וקלה לשימוש להגדרת היצרות ולהגדרת חומרת ההצרות בפיית השופכה.
חומרים ושיטות: -גויסו ילדים שאובחנו עם היצרות בפיית השופכה וילדים בריאים שיהוו קבוצת ביקורת. בוצע צילום של פיית השופכה, המטופלים ענו על תסמינים ונעשו בדיקות עזר הכוללות בדיקת זרם שתן ובדיקת על-קול להערכת שארית שתן. המחקר בוצע בשלושה שלבים: בשלב הראשון הוגדרו קריטריונים לדירוג על ידי שלושה מומחים באורולוגיית ילדים, להם הוצגו 30 תמונות של פיית שופכה. בשלב השני נעשה תיקוף לדירוג על ידי הצגתו ל-51 אורולוגים שהתבקשו לדרג 20 תמונות של פיית שופכה על פי הדירוג שהוגדר קודם לכן. בכדי לאמוד את מידת ההסכמה בין בודקים שונים (inter rater reliability) חושב מדד ה-ICC (Intra-class correlation coefficient). בכדי לאמוד את מידת ההסכמה של כל מדרג עם עצמו לאחר שבועיים (intra rater reliability) חושב מדד ה-KAPPA לכל אחד מהצילומים. בשלב השלישי נעשתה השוואה בין הדירוג לבדיקות העזר האובייקטיביות ושאלון התסמינים לצורך כך דורגו 68 תמונות מקבוצת המחקר על ידי אורולוג ילדים והושוו לבדיקות והאנמנזה שנאספו על אותם ילדים על מנת לראות אם יש התאמה.
על מנת לבדוק את הקשר בין משתנה כמותי (בדיקות העזר) למשתנה איכותי עם שלוש קטגוריות (הדירוגים לפי בדיקה גופנית), נעשה שימוש במבחן ניתוח שונות א-פרמטרי (Kruskal-Wallis) וכן נעשו השוואות מזווגות מרובות בעזרת מבחן Mann-Whitney הא-פרמטרי ותיקון לרמת המובהקות על פי בונפרוני.
הקשר בין שני משתנים קטגוריאלים (השוואה בין שאלון ההורים לבין הדירוג לפי בדיקה גופנית) נבחן על ידי "המבחן המדויק של פישר". מתאם בין תיאור צורת השתן (תמונה שהורים נתבקשו לסמן בשאלון)

לבין הדירוג, נאמד על ידי חישוב מקדם המתאם של Spearman.
כל המבחנים הסטטיסטיים היו דו- כיווניים וערך P-value של 5% או פחות נחשב כמובהק סטטיסטית.
תוצאות - במחקר השתתפו 80 מטופלים ו 6 ילדים בקבוצת הביקורת.
הדירוג שנקבע בשלב הראשון היה:
דירוג 0 - פיית השופכה פתוחה, שכבת המוקוזה נצפית, לא ניתן לראות web.
דירוג 1 - פיית השופכה פתוחה, מעט שכבת מוקוזה נצפית, ניתן לראות web.
דירוג 2 - פיית השופכה בגודל של ראש סיכה (pin point), לא ניתן לראות שכבת מוקוזה, ניתן לראות web גדול.
תיקוף הדירוג בהשוואה בין קוראים שונים inter-rater reliability היה בעל תוצאות גבוהות במבחן ה-ICC - 0.988-0.991. בהשוואה בין כל קורא לבין עצמו intra-rater reliability ב-80% מהמקרים הרופאים נתנו את אותו הדירוג. בהשוואה בין הדירוג לבין בדיקות העזר והאנמנזה נמצא קשר מובהק סטטיסטית בבדיקת זרם שתן מקסימלי (P-value=0.01) ובבדיקת זמן הגעה לזרם שתן מקסימלי (P-value=0.016).
מסקנות - לראשונה בוצע תיקוף לדירוג חומרת היצרות בפיית השופכה באמצעות תוצאות inter-rater reliability משכנעות ביותר שהתקבלו. לא נמצע קשר בין חומרת התסמינים לבין חומרת היצרות פיית השופכה כפי שהיא מתבטאת בבדיקה הפיזיקלית. לעומת זאת הוכח קשר בין חלק מבדיקות זרם השתן לבין חומרת ההיצרות כך שניתן לשלב בדיקות אובייקטיביות אלה באבחנה.

Use of the "Bogota Bag" for Temporary Abdominal Closure in Pediatric Patients: A 15 year Retrospective Study

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Background: Abdominal compartment syndrome (ACS) is caused by a pressure-volume dysregulation of the intra-abdominal contents, causing an abnormal increase in the intra-abdominal pressure. Hemodynamic compromise, multi organ dysfunction and death may occur. The etiology varies between medical and surgical causes. Until return to its original volume, a temporary decompression of the abdominal cavity is warranted. A number of such methods have been described. The "Bogota Bag" (BB) is a tension-free method which coveres abdominal contents with a sterilized fluid bag. Although widely published data regarding BB in adults exists, literature review showed only solitary cases in pediatric patients.

Methods: All Pediatric cases that underwent temporary abdominal closure were reviewed and analyzed.
Results: Between January 2000 and August 2014, 17 patients had a BB placed. Our cohort included 14 patients. Surgical indications were: multitrauma (6 cases), chronic disease complications (3), and acute disease complications (5). Indications for placement were a later need for re-exploration (6 cases), inability for primary abdominal closure (4), and high risk for ACS development (4). Median BB time was 5 days. Median time for bag replacement was 2 days. Postoperatively, all patients were admitted to an ICU and ventilated. Bacteremia upon admission was evident in 5 patients, abdominal cultures were positive in 7 cases. Intensive care length of stay (LOS) was a median of 10 days, total hospital LOS was a median of 27 days. Three patients passed away. In 2 of these cases, abdominal wall was closed primarily and BB was placed only during a second look operation.

Discussion: This report represents the largest series of children treated with BB. The technique is simple to perform, inexpensive, with minimal complications and shows good outcome in patients with risk of uncontrolled ACS. Our opinion is that the procedure is suitable for all ages, and can be used for a variety of indications without major complications. The common complication was bacterial sepsis, the procedure in itself does not reduce bacterial growth and expansion. Several other techniques for temporary abdominal closure have been described. In our opinion, use of vicryl mesh can cause more complications such as entero-cutaneous fistulae. VAC is another method for temporary abdominal closure. but requires continuous electrical an vacuum supply,

and significantly raises costs.

Conclusion: Application of BB is easy, safe, low cost, and suitable for all pediatric ages. We recommend that in unstable patients, suffering from intraabdominal catastrophies, it is safer to leave the abdomen open with BB application whenever the surgeon hesitates or feels unsure with closing the abdomen. In our opinion, BB is an efficient and available technique in resource-depleted areas.

Redo Vaginal Reconstruction using Buccal Mucosa: Initial Experience

שחזור הנרתיק עם שתל רירית הפה בילדות: נסיון ראשוני

גיא הידש, דב פודה, עפר גפרית, מרדכי דובדבני, יחזקאל לנדאו
היחידה לאורולוגית ילדים, והמחלקה לאורולוגיה, המרכז הרפואי של הדסה והאוניברסיטה העברית, ירושלים

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היצרות הנרתיק תוארה בילדות עם היפרפלזיה מולדת של האדרנל(CAH) וקלואקה, לאחר שחזורו. סיבוך זה קורה בעיקר עקב הצטלקות רקמת הנרתיק לאחר ניתוחים קודמים. אנו מתארים נסיון ראשוני של שחזור הנרתיק ותיקון ההיצרות עם שתל רירית הפה
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שיטות:
במהלך 2015 נותחו ביחידתנו שתי מטופלות (בנות 5 ו-18 שנים) שנולדו עם סינוס אורוגניטלי על רקע CAH שתיהן עברו תיקון הסינוס ושחזור הנרתיק בגילים 3, 4 שנים, וסבלו מהיצרות מבוא הנרתיק אשר לא הגיבה להרחבות. הניתוחים לשחזור הנרתיק בוצעו עם חתכים אורכיים (בשעות 5, 7) לאורך הנרתיק ושחרור ההיצרות. הפגמים שנוצרו כוסו בשתלי רירית הפה שנלקחו מהלחיים ומהשפה התחתונה.

תוצאות:
בשני המקרים הניתוחים עברו ללא סיבוכי דמם או זיהום. ריפוי הפצע וקליטת השתל היו מלאים בשני המקרים. הצלחנו להרחיב את הנרתיק של הנערה מקוטר של 1 ס"מ לקוטר של מעל 3 ס"מ (300%). בילדה, מ-4 מ"מ ל-13 מ"מ (325%). אזורי תרומת השתל בפה החלימו ללא צלקות או שינויי במפתח הפה.

מסקנות:
ניסיון ראשוני וקצר מועד זה מעלה את האפשרות שניתוח חוזר לשחזור הנרתיק עם שתל רירית הפה הינו אופציה יעילה עם תוצאות תפקודיות ואסטטיות משביעות רצון.

Pilonidal sinus disease: time for reevaluation of a problem from the …rear

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Pilonidal sinus disease is a chronic medical condition that brings significant suffering, discomfort, and embarrassment. It is a local and superficial problem in the soft tissue at the natal cleft area. It is an acquired condition due to obstruction of a hair follicle leading to infection as a foreign body reaction, frequently found in adolescents and young adults. The clinical expression of the disease is a local abscess, cellulitis, sinuses, cysts or fistula, leading to chronic discharge and discomfort.

The treatment's purpose is to remove the source of infection, minimize postoperative pain and complications, and achieve quick healing with improved cosmetic results and decrease recurrence.

In symptomatic cases with minimal findings soft tissue US of the diseased area was performed, enabling detection of somewhat occult pilonidal pathology, and giving a more informative and precise preoperative details.

There is an extensive literature on the diverse surgical approaches to pilonidal sinus disease, with varied results, some of them appearing more like real "surgical adventures". Inspired by Lord and Millar's approach and later by Gips et al we operated on 181 patients, most of them adolescents. The majority presented extensive and complex disease. Twenty three underwent a Trephine procedure, substituted by a limited excision of the lesion and marsupialization in the following 158 patients due to unfavorable results with the former technique. The vast majority the surgical procedure was done under sedation and local anesthesia, in a day care set up. Postoperative pain was minimal, with pleasing cosmetic results, fast recovery and return to normal activity. Recurrence rate seems very low, yet a more prolonged follow up is needed.

Pediatric Lower Urinary Tract Questionnaire: Validation of the Hebrew Version

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תיקוף שפה של שאלון עברי להערכת הפרעות בהטלת השתן בילדים

גיא הידש[1], יחזקאל לנדאו[1], חוה גדסי[3], יעקב בן חיים[5], דב פודה[2], עפר גפרית[2], מורדכי דובדבני[2], רחל יפה זיסק-רני[4]

1 היחידה לאורולוגית ילדים והמחלקה לאורולוגיה, המרכז הרפואי של הדסה והאוניברסיטה העברית, ירושלים

2 אגף הילדים, מרכז רפואי הדסה, ירושלים

3 בית החולים דנה לילדים המרכז הרפואי תל אביב (איכילוב)

4 ביה"ס לסיעוד של הדסה ואוניברסיטה העברית, ירושלים

שאלונים הם אחד המדדים לאבחון והערכת חומרת מחלה, והם מהווים חלק משמעותי בעבודה הקלינית, והמחקרית בכל תחום ברפואה. כשמטפלים בילד עם הפרעות בהטלת השתן יש חשיבות רבה לשימוש בשאלון איתו אפשר למדוד בצורה כמותית ואובייקטיבית את חומרת הבעיה ויעילות הטיפול אותה הילד מקבל. חשיבות נוספת היא היכולת לבצע מחקרים המשווים בין יעילות של טיפולים שונים. ה international children`s continence society פיתחו ותיקפו שאלון מדד קצר וקל למילוי שנקרא ה ICIQ.השאלון בוחן המצאות וחומרה של דליפת שתן, הרטבות לילה, תכיפות ודחיפות בהטלת השתן, מאמץ בעת מתן שתן והפרעות נוספות במתן שתן. הבעיה היא שהשאלון החשוב הזה באנגלית ולא ניתן להשתמש בו על ילדים בישראל בשפה העברית. מטרת מחקר זה הינה לתרגם את השאלון לעברית ולתקף אותו

שיטות:
תחילה תרגמנו את השאלון מאנגלית לעברית. לאחר מכן, מומחה בתחום דובר אנגלית.שלא הכיר את השאלון תרגם אותו מעברית בחזרה לאנגלית. לבסוף השוונו את המקור באנגלית עם התרגום החוזר באנגלית כדי לראות אם קיימת התאמה. כדי לבדוק האם ההורים מבינים את השאלות באותה צורה בשתי השפות ערכנו מחקר בו הורים הדוברים אנגלית וגם עברית ברמה גבוהה מאוד מילאו את שני השאלונים. בשביל למצוא את מידת הסכמה בין המענה של ההורים על כל שאלה ושאלה בשתי השפות השתמשנו במבחן ICC) Intra Class Correlation)

תוצאות:
בטבלה ניתן לראות את נוסח השאלון המתוקף בעיברית ואת ערכי ICC לכל שאלה ושאלה

מסקנות:
השאלון העברי להערכת הפרעות בהטלת השתן תקף ומתאים לשימוש קליני ומחקרי בילדי ישראל.
אנו ממליצים לאורולוגים להשתמש בשאלון זה כאשר הם מטפלים בילד המרטיב.

פרטי השאלה					ICC
באיזו תדירות הילד שלך מרטיב בלילה?	אף פעם לא(1)	בערך פעם בשבוע(2)	מספר פעמים בשבוע(3)	כל לילה(4)	**0.69**
באיזו תדירות הילד שלך מרטיב את עצמו במהלך היום?	אף פעם לא(1)	בערך פעם בשבוע, או פחות(2)	2-3 פעמים בשבוע (3)	בערך פעם ביום או יותר(4)	**1.0**
באיזו תדירות הילד שלך נותן שתן במהלך היום?	1-3 פעמים ביום(3)	4-7 פעמים ביום(1)	8-12 פעמיםביום (2)	יותר מ-12 פעמים ביום(3)	**1.0**
כשילדך צריך לתת שתן, האם הוא צריך לרוץ לשירותים באופן מיידי?	אף פעם לא (1)	לפעמים (2)	רוב הזמן (3)	כל הזמן(4)	**1.0**
האם ילדך מנסה להתאפק על ידי הצלבת רגליים, כריעה וכדומה?	אף פעם לא (1)	לפעמים (2)	רוב הזמן (3)	כל הזמן (4)	**0.92**
האם ילדך צריך ללחוץ או להפעיל מאמץ בתחילת מתן שתן?	אף פעם לא (1)	לפעמים (2)	רוב הזמן (3)	כל הזמן (4)	**1.0**
האם ילדך מרטיב את עצמו עצמך בזמן שהוא רץ לשירותים?	אף פעם לא (1)	לפעמים (2)	רוב הזמן (3)	כל הזמן (4)	**0.79**
האם ילדך חייב לרוץ לשירותים לתת שתן (להשתין) אפילו אם הוא היה שם זמן קצר לפני כן?	אף פעם לא (1)	לפעמים (2)	רוב הזמן (3)	כל הזמן (4)	**1.0**
באיזו תדירות יש לילדך פעולות מעיים (יציאות)?	כל יום (1)	יום כן יום לא (2)	פעמיים בשבוע (3)	פעם בשבוע או פחות (4)	**0.87**

Point-of-care ultrasound in a Department of Pediatric Surgery

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Objective: To describe current use, diagnostic and therapeutic impacts of point-of-care ultrasound (POCUS) in a department of Pediatric Surgery.

Background: POCUS is becoming a common tool for routine use in Emergency Room, Anesthesiology and ICU for diagnostic and interventional purposes. When a portable US machine became available for our pediatric surgical department, we added POCUS assessments to the physician's daily rounds. POCUS is performed by pediatric surgeons trained in basic US skills. Starting September 2015 all POCUS examinations were documented.

Methods: Observational study of all the documented POCUS procedures performed during a half year period. Data regarding patient condition and the POCUS procedures were collected, as well as the use of other diagnostic modalities, mainly formal US exams (by radiologists) and CT scans and their correlation with the POCUS exam.

Results: 50 POCUS exams were performed during the study period, most of them served to define the presence and resolution of a collection – intra-abdomina (34%) and subcutaneous (31%). While there was a high rate for formal diagnostic studies (65%), probably due to a relative lack of confidence of the surgeons performing the POCUS exams during this initial period, most results (92%) were similar.

The ability and availability to perform multiple POCUS exams by the attending physician proved to be a valuable adjunct to the classical physical and laboratory examinations of the surgical patients.

התוכנית החברתית

יום ה - 30.6 :

20:30 - 21:30 :
הופעה מוזיקלית של אנדראה וחגי כובש : "צלילים קסומים" - מוזיקה מהעולם בכלי נגינה שונים.

21:30 - 24:00 :
קומזיץ בחוף הים הכולל: חצי חבית, מדורה, תה צמחים, מחצלות, כיסאות חוף,

יום ו - 1.7 :

16:30 - 18:00:
סיור בהדרכה לעתיקות תל דור ולמזגגה,

21:00 - 22:00 :
הופעה של ניר חיימוביץ - אמן על חושי, המופע משלב טכניקות של טלפתיה, קריאת מחשבות וכמובן צחוק ללא הפסקה

משך כל ימי הכנס - בילוי משפחתי בחוף ים מיוחד ומהנה !

ההסתדרות הרפואית בישראל - האיגוד הישראלי לכירורגית ילדים
והחוג לאורולוגית ילדים באיגוד האורולוגים הישראלי

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