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Rare cause of abdominal incidentaloma: Hepatoduodenal ligament teratoma

Vagner Birk Jeismann, Rodrigo Blanco Dumarco, Celso di Loreto, Ricardo Correa Barbuti, José Jukemura

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This case report demonstrates that cross-sectional imaging, such as computed tomography, can reveal suspected incidences of this rare type of teratoma, which can then be confirmed after pathologic analysis of the specimen. The prognosis after complete surgical resection of lesions presenting with benign pathological features is excellent.

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Key words: Abdominal incidentaloma; Teratoma; Hepatoduodenal ligament; Surgery; Hepatobiliary surgery

Core tip: The 10th reported case of hepatoduodenal ligament teratoma is presented in a patient who underwent cross-sectional imaging for the evaluation of an abdominal mass. As incidences of hepatoduodenal ligament teratoma are extremely rare, this report may help physicians to suspect this disorder in an emergent group of patients with abdominal incidentaloma.

Abstract

The occurrence of a hepatoduodenal ligament teratoma is extremely rare, with only a few cases reported in the literature. This case report describes the discovery of a hepatoduodenal ligament lesion revealed during abdominal ultrasonography for cholelithiasis-related abdominal pain in a 27-year-old female. Cross-sectional imaging identified a 5 cm × 4 cm heterogeneous mass of fat tissue with irregular calcification located in the posterior-superior aspect of the head of the pancreas. An encapsulated lesion showing no invasion to the common bile duct or adjacent organs and vessels was exposed during laparotomy and resected. Intraoperative cholangiography during the cholecystectomy showed no abnormalities. The postoperative course was uneventful. Pathological analysis of the resected mass indicated hepatoduodenal ligament teratoma.

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INTRODUCTION

Teratomas are neoplasms comprised of mixed dermal elements derived from the three germ cell layers. Although the majority of teratomas are congenitally present in the gonads of men and women, they have been identified in extra-gonadal sites, such as the anterior mediastinum, retroperitoneum and sacrococcygeal regions^[1]. Teratomas in the hepatoduodenal ligament are extremely rare, with only nine cases described in the literature^[2-10] (Table 1). We report a case of hepatoduodenal ligament teratoma

Table 1 Reported cases of hepatoduodenal ligament teratoma (adapted and expanded with permission from Ukiyama *et al.*^[8])

Patient	1	2	3	4	5	6	7	8	9	10
Year reported	1986	1989	1993	2004	2004	2005	2008	2008	2012	2013
Ref.	Frexes <i>et al.</i> ^[2]	Akimov <i>et al.</i> ^[3]	Kim <i>et al.</i> ^[4]	Demircan <i>et al.</i> ^[5]	Wang <i>et al.</i> ^[6]	Sasaki <i>et al.</i> ^[7]	Ukiyama <i>et al.</i> ^[8]	Soufias <i>et al.</i> ^[9]	Bagga <i>et al.</i> ^[10]	Our case
Age	Neonate	6 yr	5 yr	4 mo	29 yr	38 yr	20 mo	26 yr	11 yr	27 yr
Sex	NA	NA	Male	Female	Female	Male	Male	Female	Female	Female
Origin	Extrahepatic bile duct	HL	CBD	Anomalous CBD	HL	HL	HL	HL	HL and fistulization with the CBD	HL
Signs and symptoms	Jaundice	Portal hypertension	Jaundice	Jaundice, abdominal distension	Portal hypertension	Abdominal mass	Abdominal mass	Abdominal pain	Jaundice, abdominal mass	Asymptomatic
Size	Small mass	NA	NA	Cystic mass 15 cm	Solid mass 7 cm × 6 cm × 6 cm	Cystic mass 8 cm	Solid mass 9 cm × 6 cm × 6 cm	Cystic mass 11 cm	Cystic mass 9 cm × 9 cm	5 cm × 4 cm
Pathology	Teratoma	NA	Endodermal sinus tumor associated with teratoma	Benign cystic teratoma	Benign teratoma	Benign cystic teratoma	Benign teratoma	Dermoid cyst	Benign cystic teratoma	Benign teratoma
Treatment	Local excision, recurrence, re-excision with chemotherapy	NA	Whipple's operation with chemotherapy	Extirpation with CBD	Extirpation	Extirpation with CBD, Roux-en-Y, Choledochojejunostomy	Extirpation	Excision of the tumor	Extirpation leaving the outer cyst wall in situ (Lilly technique), hepatico-duodenostomy	Extirpation
Prognosis	Asymptomatic after 5 yr	Death	Death	Asymptomatic after 4 yr	Asymptomatic after 2 yr	NA	Asymptomatic after 5 yr	Asymptomatic after 33 mo	Asymptomatic after 2 yr	Asymptomatic after 6 mo

CBD: Common bile duct; HL: Hepatoduodenal ligament; NA: Not available.

in an adult female patient examined for cholelithiasis-related abdominal pain.

CASE REPORT

A 27-year-old female presented with cholelithiasis-related pain. There was no history of jaundice, and the past medical history was unremarkable. Physical examination failed to detect the presence of an abdominal mass, and routine laboratory tests were normal. Abdominal ultrasonography revealed cholelithiasis and a mass adjacent to the hepatic hilum. Computed tomography (CT) and magnetic resonance imaging revealed a heterogeneous mass of 5 cm × 4 cm comprised of fat tissue and irregular calcifications located in the hepatoduodenal ligament at the posterior-superior aspect of the head of the pancreas (Figure 1).

Following patient consent, a laparotomy was performed. A Kocher maneuver with extensive mobilization of the duodenum exposed an encapsulated lesion. It was dissected and resected, and the multiple small vessels from the hepatic pedicle to the lesion were divided. There was no invasion of adjacent organs, vessels or the common bile duct (Figures 2 and 3). A cholecystectomy was performed and the intraoperative cholangiogram did not show abnormalities. The postoperative course was uneventful, and the patient was discharged after four days. The patient remains asymptomatic after six months. Histopathology confirmed that the mass was a mature teratoma. Microscopic examination revealed the presence of a cystic wall with cutaneous annexes and a mature neural area with glial fibrillary acidic protein immunoreactivity (Figure 4).

DISCUSSION

Teratomas are composed of structures derived from the three germ layers, namely the ectoderm, mesoderm and endoderm. Most mature teratomas are benign, but can undergo a malignant change in one of their elements^[6]. Although plain abdominal radiographs show calcification in most (60%) extra-gonadal teratomas, either in the wall of the cyst or

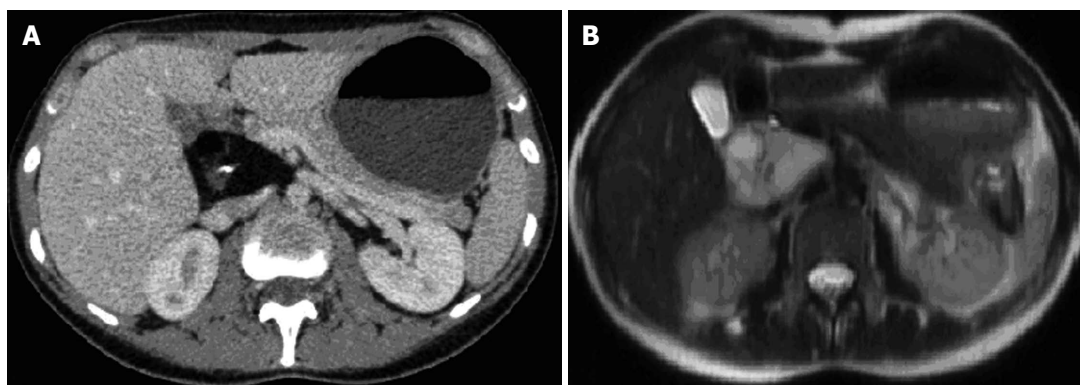


Figure 1 Cross-sectional imaging. A hepatoduodenal heterogeneous mass was revealed by A: Computed tomography; B: Magnetic resonance imaging.

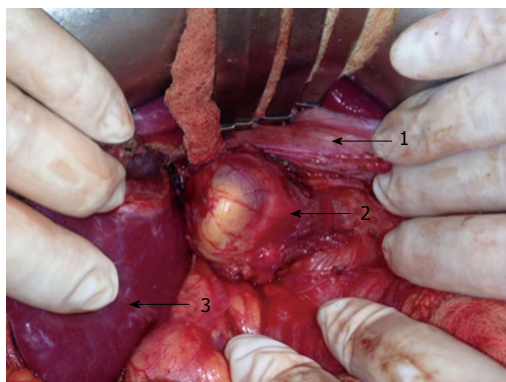


Figure 2 Operative finding. A laparotomy revealed an encapsulated lesion without invasion to adjacent organs or vessels (1: Common bile duct; 2: Teratoma; 3: Right lobe of the liver).

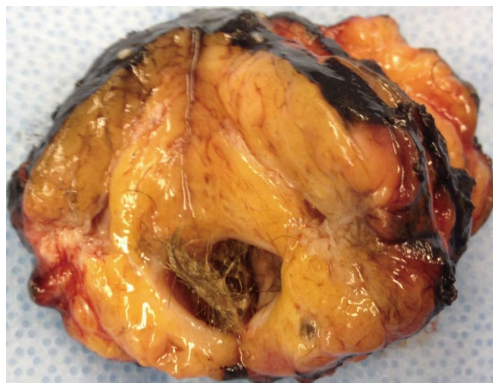


Figure 3 Tumor appearance. The resected heterogeneous lesion was composed of fat tissue, calcifications and hair.

in structures such as teeth or bones, CT is generally the most helpful imaging modality for diagnosis^[7].

An extensive review of the literature identified nine reported cases of hepatoduodenal teratoma^[2-10]. Six of the described cases were in children^[2-5,8,10], and the oldest patient identified was 38 years old at the time of diagnosis^[7]. A small gender difference is evident, as the lesions were more often described in women^[5,6,9,10]. Clinical manifestations were variable, including jaundice^[2,4,10], portal hypertension^[3,6] and a palpable abdominal mass^[7,8,10]. Some

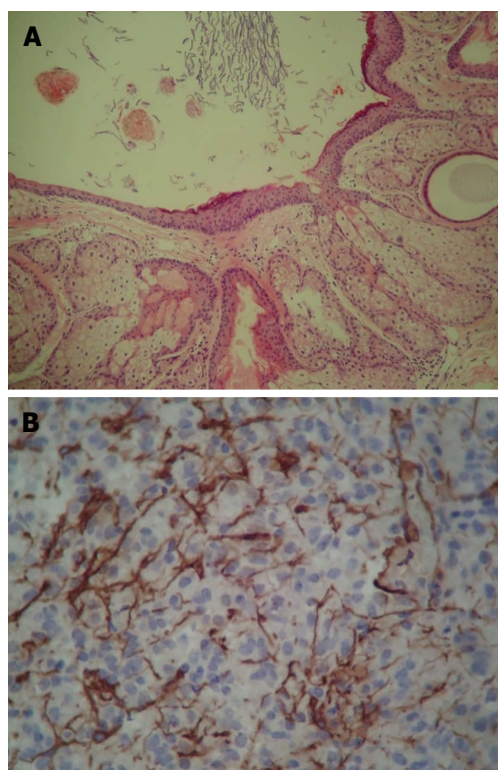


Figure 4 Histopathology of the tumor. Microscopic examination of the specimen revealed A: A cystic wall with cutaneous annexes; B: Glial fibrillary acidic protein immunoreactivity.

patients demonstrated elevated levels of serum alpha-fetoprotein, carcinoembryonic antigen and carbohydrate antigen 19-9, but these do not appear to be clinically useful^[7]. The majority of cases reported tumors with benign pathology features, except for one case with an endodermal sinus tumor^[4], and two cases that did not provide described pathology report details^[2,3]. All patients underwent surgical resection, and two patients received chemotherapy^[2,4], with only one incidence of recurrence^[2]. Since a definitive diagnosis is only achieved following histologic examination of the cyst, surgical resection remains the primary treatment with an excellent prognosis^[7]. In conclusion, this is the first reported asymptomatic case, to our knowledge, of hepatoduodenal ligament teratoma,

indicating that teratomas should not be ruled out in cases of abdominal incidentaloma.

COMMENTS

Case characteristics

The patient was asymptomatic.

Clinical diagnosis

The patient was diagnosed with abdominal incidentaloma uncovered during investigation of cholelithiasis-related abdominal pain.

Differential diagnosis

Benign and malignant abdominal tumors were alternative diagnoses.

Imaging diagnosis

A heterogeneous mass of 5 cm × 4 cm with fat tissue and irregular calcifications was located in the posterior-superior aspect of the head of the pancreas, into the hepatoduodenal ligament.

Pathological diagnosis

Analysis by microscopy revealed a mature teratoma cystic wall with cutaneous annexes and glial fibrillary acidic protein staining of a mature neural area, findings that are consistent with a teratoma.

Treatment

The patient was treated by surgical resection of the tumor.

Related reports

A hepatoduodenal teratoma is a rare occurrence and, to the best of the authors' knowledge, this is the 10th reported case and the 1st asymptomatic reported case.

Term explanation

Hepatoduodenal ligament teratoma refers to a neoplasm that is comprised of mixed dermal elements derived from the three germ cell layers and located at the portion of the lesser omentum extending between the porta hepatis of the liver and superior part of the duodenum. Computer tomography is a technology that uses computer-processed X-rays to produce cross-sectional imaging of the human body. Abdominal incidentaloma has been defined as an intraabdominal tumor found in a patient without symptoms, usually during evaluation of unrelated diseases or screening programs. Cholelithiasis is defined by the presence/formation of stones within the biliary tract, most commonly the gallbladder.

Experiences and lessons

Teratomas must be included on differential diagnosis of all abdominal incidentalomas.

Peer review

This case report provides a description of a rare disease that may be underdiagnosed due to a low index of suspicion. The pathological, radiological and

surgical findings are well documented.

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Single-incision laparoscopic cecectomy for low-grade appendiceal mucinous neoplasm after laparoscopic rectectomy

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Abstract

In this case report, we discuss single-incision laparoscopic cecectomy for low-grade appendiceal neoplasm after laparoscopic anterior resection for rectal cancer. The optimal surgical therapy for low-grade appendiceal neoplasm is controversial; currently, the options include appendectomy, cecectomy, right hemicolectomy, and open or laparoscopic surgery. Due to the risk of pseudomyxoma peritonei, complete resection without rupture is necessary. We have encountered 5 cases of low-grade appendiceal neoplasm and all 5 patients had no lymph node metastasis. We chose the appendectomy or cecectomy without lymph node dissection if preoperative imaging studies did not suspect malignancy. In the present case, we performed cecectomy without

lymph node dissection by single-incision laparoscopic surgery (SILS), which is reported to be a reduced port surgery associated with decreased invasiveness and patient stress compared with conventional laparoscopic surgery. We are confident that SILS is a feasible alternative to traditional surgical procedures for borderline tumors, such as low-grade appendiceal neoplasms.

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Key words: Single-incision laparoscopic surgery; Low-grade appendiceal mucinous neoplasm; Mucocele; Reduced port surgery

Core tip: The optimal surgical therapy for low-grade appendiceal neoplasm is controversial. Due to the risk of pseudomyxoma peritonei, complete resection without rupture is necessary. We performed single-incision laparoscopic surgery (SILS), which is reported to be a reduced port surgery associated with decreased invasiveness and patient stress compared with conventional laparoscopic surgery. We are confident that SILS is a feasible alternative to traditional surgical procedures for borderline tumors, such as low-grade appendiceal neoplasms.

Fujino S, Miyoshi N, Noura S, Shingai T, Tomita Y, Ohue M, Yano M. Single-incision laparoscopic cecectomy for low-grade appendiceal mucinous neoplasm after laparoscopic rectectomy. *World J Gastrointest Surg* 2014; 6(5): 84-87 Available from: URL: <http://www.wjgnet.com/1948-9366/full/v6/i5/84.htm> DOI: <http://dx.doi.org/10.4240/wjgs.v6.i5.84>

INTRODUCTION

Appendiceal mucocele is an uncommon pathology of the

appendix (0.08%-0.15% of all appendectomies) that is characterized by the accumulation of mucus in the appendiceal lumen^[1,2]. The term mucocele, includes cystadenoma and low-grade appendiceal neoplasm, and is the same as the World Health Organization (WHO)'s classification of low-grade appendiceal neoplasm. Several optimal surgical methods are reported but are still controversial. Complete resection without rupture is definitely necessary because the dissemination of neoplastic cells and mucus in the abdominal cavity, which is often caused by appendiceal perforation, clinically results in pseudomyxoma peritonei in 10%-15% of cases^[3]. Therefore, low-grade appendiceal neoplasms are classified into carcinoma groups in the WHO's classification. In several reports, the surgical procedures used vary from simple appendectomy to right hemicolectomy^[4]. Here, to identify the optimal surgical method to treat appendiceal mucocele, we report the case of a 49-year-old woman with an appendiceal lesion that was laparoscopically resected by a single incision and summarize other cases that involved surgical resections.

CASE REPORT

A 49-year-old woman underwent laparoscopic anterior resection for rectal cancer at Osaka Medical Center for Cancer and Cardiovascular Diseases in February 2009. During routine postoperative care, a mucus-filled lesion in the appendix was detected by computed tomography (CT). The patient's past medical history was not remarkable, except for the rectal cancer. Upon physical examination, there were no remarkable findings. Laboratory tests were within normal ranges. CT revealed a 55 mm × 25 mm tumor that presented as a blind-ended, tubular-shaped, fluid-filled structure in the cecum (Figure 1). Colonoscopy showed that the lesion was covered by normal colonic mucosa in the closed appendix. A colonoscopic biopsy revealed normal mucosa (Figure 2). The lesion was thought to be an appendiceal mucocele of the appendix, and single-incision laparoscopic surgery (SILS) was performed. The surgical choice was made because ultrasound examination showed a movable appendix including the surrounding intestine and no adhesion around the umbilical portion, which had an old scar from the primary operation. Under general anesthesia, the operation started with a trans-umbilical, 2.5 cm-diameter incision (SILS port). A Lap Protector (Hakko Co. Ltd., Nagano, Japan) was folded and the bottom half was inserted into the abdomen through the umbilical incision. The EZ Access (Hakko) was adjusted, and three devices were introduced through it: a flexible laparoscope (Olympus, Tokyo, Japan) and two operating forceps. The pneumoperitoneum was set at 10 mmHg. A smooth and mucus-filled lesion of the appendix was found and there were no ascites or peritoneal nodules indicating malignancy (Figure 3). To excise the tumor without rupture, we cut the peritoneum around the cecum and mobilized it without touching the tumor. After pulling the cecum with the tumor through the SILS port, a cecectomy which included the swollen appendix was performed using a linear stapler (Endo GIA universal; Covidien, Mansfield,

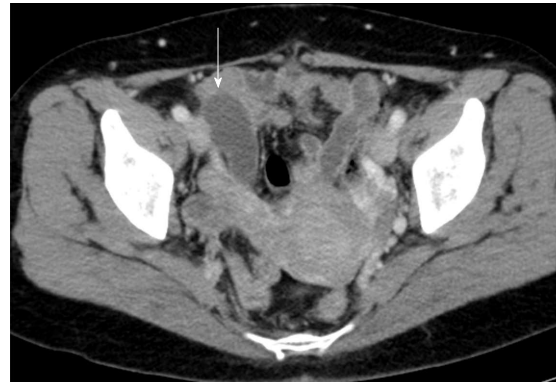


Figure 1 Computed tomography. The arrow shows a 55 mm × 25 mm, low-density and no-contrast lesion at the appendix.

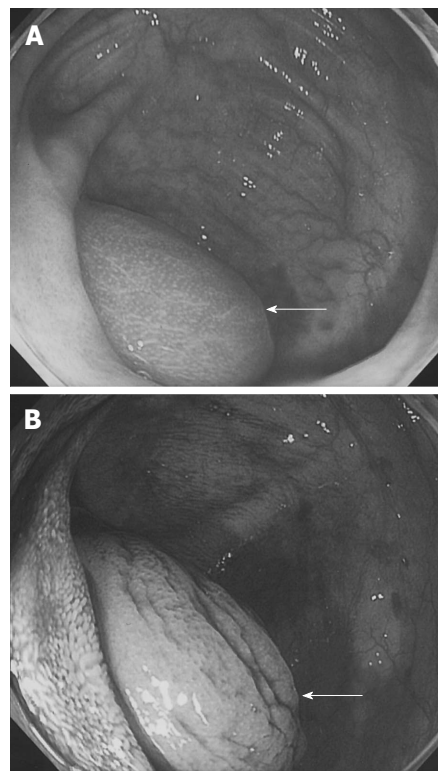


Figure 2 Colonoscopy. A: Normal image; B: Indigo carmine-stained image. There was an inflated lesion covered with normal mucosa in the appendix, suggesting a tumor under the cecal mucosa (arrows).

MA, United States). The resected bowel contained the appendix (8 cm) and cecum (1 cm). The total operating time was 57 min, and the blood loss was minimal. Histological examination showed low grade epithelial dysplasia, a feature diagnostic of a low-grade appendiceal mucinous neoplasm (Figure 4). Surgical margin was negative and no lymph node metastasis was discovered. The patient recovered without any complications, and was discharged on postoperative day 6. She returned to work, and she is now doing well without any complaint postoperatively.

DISCUSSION

Appendiceal mucocele itself does not have typical clini-

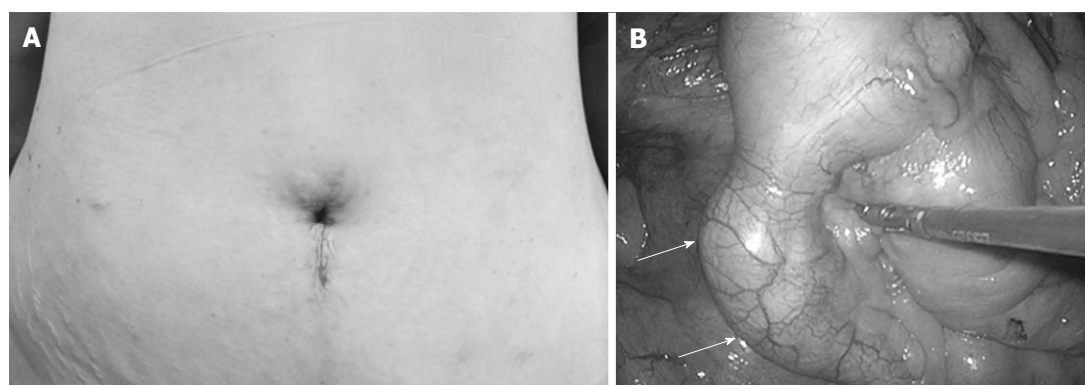


Figure 3 Photograph of the operation. A: A 2.5 cm-diameter incision was in the navel; B: The swollen appendix (arrows) and cecum were mobilized by non-touch technique.

Table 1 Six cases of mucocoele of appendix in our hospital

Case	Age (yr) /sex	Chief complaint	Tumor size (mm)	Pathological findings	Operative procedures (lymph node dissection ¹)	Bleeding (mL)	Operation time (min)	Time after surgery (mo)	Recurrence/survival
1	49/F	None	55 × 25	Low-grade appendiceal mucinous neoplasm	Single incision	5	57	6	None/alive
2	61/M	Right lower abdominal pain	90 × 40	Low-grade appendiceal mucinous neoplasm	Laparoscopic cecectomy	30	251	14	None/alive
3	61/F	None	30 × 15	Low-grade appendiceal mucinous neoplasm	Laparoscopy-assisted ileocecal resection (D3)	70	140	25	None/alive
4	81/F	None	150 × 40	Low-grade appendiceal mucinous neoplasm	Open appendectomy	70	125	29	None/alive
5	69/F	None	46 × 27	Low-grade appendiceal mucinous neoplasm	Open ileocecal resection (D3)	50	134	32	None/alive
6	51/F	Right hypochondrial pain	30 × 30	Mucinous cystadenoma	Open appendectomy	65	280	74	None/alive
					Laparoscopy-assisted ileocecal resection (D1)				

¹The defined lymph node dissection was performed according to the JSCCR guideline^[12].



Figure 4 Macroscopic image of the removed specimen. The appendix was about 8 cm long and swollen and exhibited a fibrotic wall (arrow; the mucus in the lumen was removed).

cal features; more than two-thirds of patients have their appendiceal mucocoele removed based on incidental findings, as was the case for our patient^[4]. Surgical resection without rupture is necessary, and laparoscopic appendectomy is often used in accordance with the accepted treatment of mucocoele^[2]. Based on the tumor characteristics, including the location and size, surgical management should differ. Using either an open or a minimally invasive technique still depends on the situation and the pref-

erence and experience of the surgeon. Although an open procedure is still recommended in certain appendiceal cases, especially for those with suspected malignancy^[5], the laparoscopic technique has been described and recommended as the first choice for treating this disease, rather than conventional open laparotomy. This recommendation is due to the method's ability to provide useful information regarding the entire abdominal cavity, short recovery post-surgery, and a minimized risk of seeding the tumor during laparoscopic manipulation^[6]. Furthermore, SILS has been often applied in several fields, and in colectomies^[7-11]. Recent reports show single incision approach through the umbilicus that is called SILS port or grove method. The narrow working space for surgical manipulation for surgical manipulation presents a technical difficulty; however, in certain cases, it is still easy and safe to convert to the conventional laparoscopic surgery with multiple ports or open laparotomy. Laparoscopic surgery has the added benefit of the laparoscope magnifying the surgical field, keeping the surgical space wide by aeroperitoneum. Additionally, in our case, the SILS operation was started but could have been changed to any operation, such as conventional laparoscopic surgery or open surgery, if we had encountered any difficulties (*e.g.*, bleeding, injury to other organs, or difficult surgical manipulation). In a case using the McBurney method, a tra-

ditional approach for treating an appendiceal locus with a minimized incision, it would be difficult to change the surgical procedure, leaving only the option of increasing the size of the incision.

We have encountered 6 cases of low-grade appendiceal neoplasm (Table 1); three cases were treated by open surgery for the reason described above, whereas the other 3 cases underwent laparoscopic surgery. In these cases, we chose the appendectomy or cecectomy without lymph node dissection if preoperative imaging studies did not suspect malignancy. In the present case, CT revealed no involvement of the mesoappendix or local lymph node metastasis. All 6 patients are doing well, without recurrence for 6-74 mo after surgery.

It is thought that minimally invasive procedures, including SILS appendectomy and cecectomy, for low-grade neoplasm, such as mucocoele will be considered as the primary treatment choice in several years. The potential benefits include the superior cosmetic results, reduced postoperative pain, faster recovery, and shorter hospital stays.

COMMENTS

Case characteristics

A 49-year-old woman had no symptom and the disease was detected by computed tomography (CT) during the follow-up course of rectal cancer.

Clinical diagnosis

Physical examination shows no remarkable findings.

Differential diagnosis

Appendiceal cancer, carcinoid and cystadenoma.

Laboratory diagnosis

All laboratory tests were within normal ranges.

Imaging diagnosis

CT revealed a 55 mm × 25 mm tumor, which presented as a blind-ended, tubular-shaped, fluid-filled structure in the cecum and colonoscopy showed the lesion covered by normal colon mucosa in the closed appendix.

Pathological diagnosis

Histological examination showed low-grade epithelial dysplasia, a feature diagnostic of a low-grade appendiceal mucinous neoplasm.

Treatment

The tumor was resected by single-incision laparoscopic surgery (SILS).

Related reports

SILS has been often applied in several fields, and in colectomies.

Term explanation

SILS is used as a reduced port surgery compared to conventional laparoscopic surgery (mostly 5 ports).

Experiences and lessons

This case report shows that SILS is considered as the primary treatment choice

for low-grade neoplasm, such as mucocoele.

Peer review

Report is well written. This is an interesting well-described study. The review is well conducted. It addresses an interesting clinical area in an application that has not received a great deal of attention.

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GENERAL INFORMATION

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WJGS covers topics concerning micro-invasive surgery; laparoscopy; hepatic, biliary, pancreatic and splenic surgery; surgical nutrition; portal hypertension, as well as associated subjects. The current columns of *WJGS* include editorial, frontier, diagnostic advances, therapeutics advances, field of vision, mini-reviews, review, topic highlight, medical ethics, original articles, case report, clinical case conference (clinicopathological conference), and autobiography. Priority publication will be given to articles concerning diagnosis and treatment of gastrointestinal surgery diseases. The following aspects are covered: clinical diagnosis, laboratory diagnosis, differential diagnosis, imaging tests, pathological diagnosis, molecular biological diagnosis, immunological diagnosis, genetic diagnosis, functional diagnostics, and physical diagnosis; and comprehensive therapy, drug therapy, surgical therapy, interventional treatment, minimally invasive therapy, and robot-assisted therapy.

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Acknowledgments

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Format

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- 1 **Jung EM**, Clevert DA, Schreyer AG, Schmitt S, Rennert J, Kubale R, Feuerbach S, Jung F. Evaluation of quantitative contrast harmonic imaging to assess malignancy of liver tumors: A prospective controlled two-center study. *World J Gastroenterol*

2007; **13**: 6356-6364 [PMID: 18081224 DOI: 10.3748/wjg.13.6356]

Chinese journal article (list all authors and include the PMID where applicable)

- 2 **Lin GZ**, Wang XZ, Wang P, Lin J, Yang FD. Immunologic effect of Jianpi Yishen decoction in treatment of Pixu-diarrhoea. *Shijie Huaren Xiaohua Zazhi* 1999; **7**: 285-287

In press

- 3 **Tian D**, Araki H, Stahl E, Bergelson J, Kreitman M. Signature of balancing selection in Arabidopsis. *Proc Natl Acad Sci USA* 2006; In press

Organization as author

- 4 **Diabetes Prevention Program Research Group**. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. *Hypertension* 2002; **40**: 679-686 [PMID: 12411462 DOI:10.1161/01.HYP.0000035706.28494.09]

Both personal authors and an organization as author

- 5 **Vallancien G**, Emberton M, Harving N, van Moorselaar RJ; Alf-One Study Group. Sexual dysfunction in 1, 274 European men suffering from lower urinary tract symptoms. *J Urol* 2003; **169**: 2257-2261 [PMID: 12771764 DOI:10.1097/01.ju.0000067940.76090.73]

No author given

- 6 21st century heart solution may have a sting in the tail. *BMJ* 2002; **325**: 184 [PMID: 12142303 DOI:10.1136/bmj.325.7357.184]

Volume with supplement

- 7 **Geraud G**, Spierings EL, Keywood C. Tolerability and safety of frovatriptan with short- and long-term use for treatment of migraine and in comparison with sumatriptan. *Headache* 2002; **42** Suppl 2: S93-99 [PMID: 12028325 DOI:10.1046/j.1526-4610.42.s2.7.x]

Issue with no volume

- 8 **Banit DM**, Kaufer H, Hartford JM. Intraoperative frozen section analysis in revision total joint arthroplasty. *Clin Orthop Relat Res* 2002; **(401)**: 230-238 [PMID: 12151900 DOI:10.1097/0000-3086-200208000-00026]

No volume or issue

- 9 Outreach: Bringing HIV-positive individuals into care. *HRS-A Careaction* 2002; 1-6 [PMID: 12154804]

Books

Personal author(s)

- 10 **Sherlock S**, Dooley J. Diseases of the liver and biliary system. 9th ed. Oxford: Blackwell Sci Pub, 1993: 258-296

Chapter in a book (list all authors)

- 11 **Lam SK**. Academic investigator's perspectives of medical treatment for peptic ulcer. In: Swabb EA, Azabo S. Ulcer disease: investigation and basis for therapy. New York: Marcel Dekker, 1991: 431-450

Author(s) and editor(s)

- 12 **Breedlove GK**, Schorfheide AM. Adolescent pregnancy. 2nd ed. Wiecezorek RR, editor. White Plains (NY): March of Dimes Education Services, 2001: 20-34

Conference proceedings

- 13 **Harnden P**, Joffe JK, Jones WG, editors. Germ cell tumours V. Proceedings of the 5th Germ cell tumours Conference; 2001 Sep 13-15; Leeds, UK. New York: Springer, 2002: 30-56

Conference paper

- 14 **Christensen S**, Oppacher F. An analysis of Koza's computational effort statistic for genetic programming. In: Foster JA, Lutton E, Miller J, Ryan C, Tettamanzi AG, editors. Genetic programming EuroGP 2002: Proceedings of the 5th European Conference on Genetic Programming; 2002 Apr 3-5; Kinsdale, Ireland. Berlin: Springer, 2002: 182-191

Electronic journal (list all authors)

- 15 Morse SS. Factors in the emergence of infectious diseases. Emerg Infect Dis serial online, 1995-01-03, cited 1996-06-05; 1(1): 24 screens. Available from: URL: <http://www.cdc.gov/ncidod/cid/index.htm>

Patent (list all authors)

- 16 **Pagedas AC**, inventor; Ancel Surgical R&D Inc., assignee. Flex-

ible endoscopic grasping and cutting device and positioning tool assembly. United States patent US 20020103498. 2002 Aug 1

Statistical data

Write as mean \pm SD or mean \pm SE.

Statistical expression

Express *t* test as *t* (in italics), *F* test as *F* (in italics), chi square test as χ^2 (in Greek), related coefficient as *r* (in italics), degree of freedom as *v* (in Greek), sample number as *n* (in italics), and probability as *P* (in italics).

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Italics

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