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Data di nascita: 22/11/1987

Nazionalità: Italiana

Sesso: Maschile

CONTATTI



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ESPERIENZA LAVORATIVA

01/10/2018 – ATTUALE Frattamaggiore, Italia

Dirigente Medico di I Livello - Specialista in Chirurgia Generale ASL Napoli 2 Nord - Ospedale San Giovanni di Dio

- Dirigente Medico di I Livello presso l'UOC di Chirurgia Generale e laparoscopica dell'Ospedale San Giovanni di Dio di Frattamaggiore (NA)
- Responsabile Ambulatorio di Chirurgia Bariatrica presso l'UOC di Chirurgia Generale e laparoscopica dell'Ospedale San Giovanni di Dio di Frattamaggiore (NA)
- Esperto nell'approccio laparoscopico per la chirurgia addominale maggiore

Impresa o settore Sanità e assistenza sociale | **Dipartimento** UOC Chirurgia Generale e Laparoscopica | **Indirizzo** Via Giovanni XXIII, Ospedale San Giovanni di Dio, 80027, Frattamaggiore, Italia | **Sito Internet** <https://www.aslnapoli2nord.it/>

05/03/2018 – 30/09/2018 Vicenza, Italia

Libero Professionista - Specialista in Chirurgia Generale Casa di Cura Villa Berica

Aiuto del Prof. Giusto Pignata presso l'UO di Chirurgia Generale e Laparoscopica della Casa di Cura Villa Berica. Durante tale periodo ho preso parte come aiuto e come primo operatore ad oltre 100 interventi di chirurgia laparoscopica maggiore (Resezioni coliche, Nefrectomie, Chirurgia Bariatrica)

Impresa o settore Sanità e assistenza sociale | **Dipartimento** Chirurgia Generale | **Indirizzo** Via Capparozzo 10, 36100, Vicenza, Italia | **Sito Internet** www.villaberica.it

20/03/2019 – 30/08/2020 Napoli, Italia

Chirurgo Volontario presso DAI Gastroenterologia, Endocrinologia e Chirurgia Endoscopica AOUP Federico II

Durante il periodo di volontariato presso il DAI Gastroenterologia, Endocrinologia e Chirurgia Endoscopica della AOUP Federico II di Napoli ho potuto integrare e perfezionare le tecniche di chirurgia maggiore con approccio laparoscopico. Durante tale periodo, inoltre, ho collaborato alla stesura e produzione di numerosi lavori scientifici pubblicati su riviste chirurgiche con Impact Factor.

Impresa o settore Sanità e assistenza sociale | **Dipartimento** DAI Gastroenterologia, Endocrinologia e Chirurgia Endoscopica | **Indirizzo** Via Pansini 5, 80131, Napoli, Italia | **Sito Internet** www.policlinico.unina.it

24/07/2017 – 04/03/2018 Trento, Italia

Assistente Volontario presso UOC Chirurgia Generale e Mininvasiva Ospedale San Camillo

Durante il periodo come assistente volontario presso la UOC Chirurgia Generale e Mininvasiva, dell'Ospedale San Camillo di Trento, diretta dal Prof. Giusto Pignata ho preso parte come aiuto e come primo operatore ad oltre 200 interventi di chirurgia laparoscopica maggiore (Resezioni coliche, Nefrectomie, Chirurgia Bariatrica, chirurgia di parete), potendo affinare le tecniche chirurgiche laparoscopiche.

ISTRUZIONE E FORMAZIONE

04/07/2012 – 10/07/2017 Napoli, Italia

Specializzazione in Chirurgia Generale (50 e Lode/50) AOUP Federico II di Napoli

Indirizzo Via Pansini 5, Napoli, Italia | **Sito Internet** www.policlinico.unina.it | **Voto finale** 50 e lode/50

21/07/2011 – ATTUALE Napoli, Italia

Laurea in Medicina e Chirurgia (110/110) AOUP Federico II di Napoli

Indirizzo Via Pansini 5, Napoli, Italia | **Sito Internet** www.policlinico.unina.it | **Voto finale** 110/110

13/03/2012 – ATTUALE

Iscrizione all'Albo Professionale dei Medici Chirurghi Ordine dei Medici Chirurghi di Caserta

Indirizzo N° di iscrizione CE7091

Napoli

Abilitazione all'esercizio della Professione Medica AUOP Federico II

Indirizzo Via Pansini 5, Napoli

2000 – 2005 Caserta, Italia

Diploma Liceo Scientifico (100/100) Istituto Salesiano Sacro Cuore di Maria

Indirizzo Via Roma 73, Caserta, Italia

COMPETENZE LINGUISTICHE

LINGUA MADRE: italiano

Altre lingue:

inglese

Ascolto
C1

Lettura
C1

Produzione orale
C1

Interazione orale
C1

Scrittura
C1

francese

Ascolto
B1

Lettura
B1

Produzione orale
B1

Interazione orale
B1

Scrittura
B1

COMPETENZE DIGITALI

INFORMATICHE

Microsoft Office | Social Network | google suite

EDITING VIDEO ED IMMAGINI

DaVinci Resolve | Pinnacle | Final Cut | Adobe After Effect | Adobe Photoshop | Adobe Premiere Pro

SISTEMI OPERATIVI

Windows | Linux | OSX

PROGRAMMI DI STATISTICA

SPSS | Graphpad Prism | XLStat

ULTERIORI INFORMAZIONI

Pubblicazioni

[IFSO Update Position Statement on One Anastomosis Gastric Bypass \(OAGB\)](#) 2021

Abstract

The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) issued a position statement on the role of one anastomosis gastric bypass (OAGB) in the field of bariatric/metabolic surgery in 2018 De Luca et al. (Obes Surg. 28(5):1188-206, 2018). This position statement was issued by the IFSO OAGB task force and approved by the IFSO Scientific Committee and IFSO Executive Board. In 2018, the OAGB task force recognized the necessity to update the position statement in the following 2 years since additional high-quality data could emerge. The updated IFSO position statement on OAGB was issued also in response to inquiries to the IFSO by society members, universities, hospitals, physicians, insurances, patients, policy makers, and media. The IFSO position statement on OAGB has been reviewed within 2 years according to the availability of additional scientific evidence. The recommendation of the statement is derived from peer-reviewed scientific literature and available knowledge. The IFSO update position statement on OAGB will again be reviewed in 2 years provided additional high-quality studies emerge.

[Changes in surgical behaviOrs dUring the CoviD-19 pandemic. The SICE CLOUD19 Study](#) 2021**Abstract****Background**

The spread of the SARS-CoV2 virus, which causes COVID-19 disease, profoundly impacted the surgical community. Recommendations have been published to manage patients needing surgery during the COVID-19 pandemic. This survey, under the aegis of the Italian Society of Endoscopic Surgery, aims to analyze how Italian surgeons have changed their practice during the pandemic.

Methods

The authors designed an online survey that was circulated for completion to the Italian departments of general surgery registered in the Italian Ministry of Health database in December 2020. Questions were divided into three sections: hospital organization, screening policies, and safety profile of the surgical operation. The investigation periods were divided into the Italian pandemic phases I (March–May 2020), II (June–September 2020), and III (October–December 2020).

Results

Of 447 invited departments, 226 answered the survey. Most hospitals were treating both COVID-19-positive and -negative patients. The reduction in effective beds dedicated to surgical activity was significant, affecting 59% of the responding units. 12.4% of the respondents in phase I, 2.6% in phase II, and 7.7% in phase III reported that their surgical unit had been closed. 51.4%, 23.5%, and 47.8% of the respondents had at least one colleague reassigned to non-surgical COVID-19 activities during the three phases. There has been a reduction in elective (> 200 procedures: 2.1%, 20.6% and 9.9% in the three phases, respectively) and emergency (< 20 procedures: 43.3%, 27.1%, 36.5% in the three phases, respectively) surgical activity. The use of laparoscopy also had a setback in phase I (25.8% performed less than 20% of elective procedures through laparoscopy). 60.6% of the respondents used a smoke evacuation device during laparoscopy in phase I, 61.6% in phase II, and 64.2% in phase III. Almost all responders (82.8% vs. 93.2% vs. 92.7%) in each analyzed period did not modify or reduce the use of high-energy devices.

Conclusion

This survey offers three faithful snapshots of how the surgical community has reacted to the COVID-19 pandemic during its three phases. The significant reduction in surgical activity indicates that better health policies and more evidence-based guidelines are needed to make up for lost time and surgery not performed during the pandemic.

PMID: 33656697 PMCID: PMC7926077 DOI: 10.1007/s13304-021-01010-w

[Laparoscopic gastrectomy for stage II and III advanced gastric cancer: long-term follow-up data from a Western multicenter retrospective study](#)

2021

Abstract

Introduction: There has been an increasing interest for the laparoscopic treatment of early gastric cancer, especially among Eastern surgeons. However, the oncological effectiveness of Laparoscopic Gastrectomy (LG) for Advanced Gastric Cancer (AGC) remains a subject of debate, especially in Western countries where limited reports have been published. The aim of this paper is to retrospectively analyze short- and long-term results of LG for AGC in a real-life Western practice.

Materials and methods: All consecutive cases of LG with D2 lymphadenectomy for AGC performed from January 2005 to December 2019 at seven different surgical departments were analyzed retrospectively. The primary outcome was diseases-free survival (DFS). Secondary outcomes were overall survival (OS), number of retrieved lymph nodes, postoperative morbidity and conversion rate.

Results: A total of 366 patients with stage II and III AGC underwent either total or subtotal LG. The mean number of harvested lymph nodes was 25 ± 14 . The mean hospital stay was 13 ± 10 days and overall postoperative morbidity rate 27.32%, with severe complications (grade $\geq$ III) accounting for 9.29%. The median follow-up was 36 ± 16 months during which 90 deaths occurred, all due to disease progression. The DFS and OS probability was equal to 0.85 (95% CI 0.81–0.89) and 0.94 (95% CI 0.92–0.97) at 1 year, 0.62 (95% CI 0.55–0.69) and 0.63 (95% CI 0.56–0.71) at 5 years, respectively.

Conclusion: Our study has led us to conclude that LG for AGC is feasible and safe in the general practice of Western institutions when performed by trained surgeons.

Keywords: Advanced gastric cancer; Laparoscopic gastrectomy; Laparoscopy; Malignancy; Stomach

PMID: 33877411 DOI: 10.1007/s00464-021-08505-y

[Correction to: Changes in surgical behaviOrs dUring the CoviD-19 pandemic. The SICE CLOUD19 Study](#) 2021

Smoke Evacuation During Laparoscopic Surgery: A Problem Beyond the COVID-19 Period. A Quantitative Analysis of CO₂ Environmental Dispersion Using Different Devices

2021

Abstract

Background. The COVID-19 pandemic leads to several debates regarding the possible risk for healthcare professionals during surgery. SAGES and EAES raised the issue of the transmission of infection through the surgical smoke during laparoscopy. They recommended the use of smoke evacuation devices (SEDs) with CO₂ filtering systems. The aim of the present study is to compare the efficacy of different SEDs evaluating the CO₂ environmental dispersion in the operating theater. **Methods.** We prospectively evaluated the data of 4 group of patients on which we used different SEDs or standard trocars: AIRSEAL system (S1 group), a homemade device (S2 group), an AIRSEAL system + homemade device (S3 group), and with standard trocars and without SED (S4 group). Quantitative analysis of CO₂ environmental dispersion was carried out associated to the following data in order to evaluate the pneumoperitoneum variations: a preset insufflation pressure, real intraoperative pneumoperitoneum pressure, operative time, total volume of insufflated CO₂, and flow rate index. **Results.** 16 patients were prospectively enrolled. The [CO₂] mean value was 711 ppm, 641 ppm, 593 ppm, and 761 ppm in S1, S2, S3, and S4 groups, respectively. The comparison between data of all groups showed statistically significant differences in the measured ambient CO₂ concentration. **Conclusion.** All tested SEDs seem to be useful to reduce the CO₂ environmental dispersion respect to the use of standard trocars. The association of AIRSEAL system and a homemade device seems to be the best solution combining an adequate smoke evacuation and a stable pneumoperitoneum during laparoscopic surgery.

Keywords: CO₂; COVID-19; SARS-COV-2; laparoscopic surgery; smoke evacuation device

PMID: 33961529 DOI: 10.1177/15533506211014857

Use of the ORBEYE™ Exoscope in General Surgery: The Advent of Video-Assisted Open Surgery 2020

Abstract

Background. Microsurgery has quickly become the "gold standard" approach for vascular surgical steps during neurosurgery. However, despite its advantages, the microscope has not been widely adopted in general surgery. A new 3D-surgical exoscope, the ORBEYETM, has been developed and introduced to some surgical specialties. Herein, we present our preliminary experience with the ORBEYETM exoscope as applied to a number of general surgical procedures. **Method.** Throughout February 2020, 7 patients had undergone varying surgical procedures at our institute utilizing the ORBEYETM in some of specific procedural steps where the surgeons felt that the surgery would benefit from more enhanced magnification. Upon completion, all the surgeons who had taken part in the procedure were asked if they had experienced any nausea, dizziness, or eyestrain during its use. **Results.** The ORBEYETM was employed in a number of surgical steps for the following procedures: throughout an inguinal hernia repair, during a duodeno-cephalo-pancreatectomy, for a subtotal gastrectomy, during para-aortic mass dissection, and during Ivor Lewis procedure. None of the surgeons involved in the procedures reported experiencing any nausea, dizziness nor eyestrain, nor any other physical discomforts. **Conclusion.** To the best of our knowledge, ours is the very first report on the employment of the ORBEYE exoscope during general surgery. Our experience assures us that this highly ergonomic technology with its high-resolution 4K 3D optical system allows the surgeon to perform safe and precise surgery in several dedicated steps in which adequate magnification is required with no adverse effects to the surgeon or the surgical procedure itself.

Does a 3D laparoscopic approach improve surgical outcome of mininvasive right colectomy? A retrospective case-control study

2020

Abstract

Laparoscopy has gained wide acceptance due its benefits for patients. However, advanced laparoscopic procedures are still challenging. One critical issue is lack of stereoscopic vision. Despite its diffusion, the totally laparoscopic approach for right hemicolectomy (TLRC) is still debated due to its difficulty, particularly for fashioning of the ileocolic anastomosis. The aim of this multicenter study is to investigate whether 3D vision offers any advantages on surgical performance over 2D vision during TLRC. All data of consecutive patients who underwent elective TLRC for cancer at three Italian surgical centers with either 2D or 3D technology from January 2013 to December 2018 were retrieved from a computer-maintained database. A case-matched analysis using the Mantel-Haenszel method was performed. After matching, a total of 106 patients were analyzed with 53 patients in each group. Mean operative time was significantly longer for 2D-TLRC than for 3D-TLRC (153.2 ± 52.4 vs. 131 ± 51 min, $p = 0.029$) and a statistically significant difference in anastomosing time ($p = 0.032$, 19.2 ± 5.9 min vs. 21.7 ± 6.2 min for 3D and 2D group, respectively) was also recorded. No difference in the median number of harvested nodes (23 ± 11 vs. 21 ± 7 for 3D and 2D group, respectively; $p = 0.48$) was found. Neither intraoperative complications nor conversions occurred in the two groups. In conclusion, 3D vision appears to improve the performance of a TLRC by reducing operative time and making intracorporeal anastomosis easier. Prospective randomized studies are required to determine the real beneficial effects.

A New Strategy for a High Tumour Burden Region: The Campania Oncological Network 2020

[Learning curve in open inguinal hernia repair: a quality improvement multicentre study about Lichtenstein technique](#)

2020

Abstract

Purpose: Inguinal hernia repair is one of the most performed procedure all over the world with more than 20 million procedures performed each year. Due to the lack of data in literature about the learning curve of the Lichtenstein procedure, we decided to reproduce a research on learning curves with the same methodology proposed in our previous study about laparoscopic hernia repair. The aim of this multicentre study was to analyse how many cases are required to achieve the learning curve for a Lichtenstein procedure.

Methods: We performed a retrospective analysis of the first 100 Lichtenstein procedures performed by 4 trainees from three different institutions and compared them with the same number of procedures performed by 3 senior surgeons from the same institutions. The data about the achieving of learning curve were evaluated with CUSUM and KPSS test.

Results: No differences about biometrical features were found between the seven groups of patients. CUSUM analysis showed that the trainees achieve the learning curve after 37-42 procedures, reaching an operative time similar to that one of the senior surgeons.

Conclusions: In conclusion, we have shown that the number of procedures required to reach the learning curve from the beginning of surgical residency is around 40 hernia repairs. This number, produced in a controlled environment under strict supervision, could be the minimum requirement to start the procedure of accreditation and specialization in hernia surgery and is higher and steeper than previously reported.

[Is robotic right colectomy economically sustainable? a multicentre retrospective comparative study and cost analysis](#)

2020

Abstract

Background: Following the Food and Drug Administration approval, robot-assisted colorectal surgery has gained more acceptance among surgeons. One of the open issues about robotic surgery is the economic sustainability. The aim of our study is to evaluate the economic sustainability of robotic as compared to laparoscopic right colectomy for the Italian National Health System.

Methods: We performed a retrospective multicentre case-matched study including 94 patients for each group from four different Italian surgical departments. An economic evaluation gathered from a real-world data was performed to assess the sustainability of the robotic approach for right colectomy in the Italian National Health System. In particular, a differential cost analysis between the two procedures was performed.

Results: No statistical differences were found between the two groups for postoperative outcomes. After a careful review of the literature on the cost assessment for the operative room, medical devices and hospital stay according with our data, we estimated the followings: (a) the mean operative room cost for robotic group was 2179 ± 476 € vs. 1376 ± 322 € for laparoscopic group; (b) the mean hospital stay cost for robotic group was 3143 ± 1435 € vs. 3292 ± 1123 € for laparoscopic group; and (c) the mean cost for instruments was 6280 € for robotic group vs. 1504 € for laparoscopic group. The total mean cost of robotic right colectomy was $11,576 \pm 1915$ € vs. 6196 ± 1444 € for laparoscopic right colectomy.

Conclusion: In conclusion, to date, robotic right colectomy with intracorporeal anastomosis does not provide any significant clinical advantages, which may justify the additional costs, as compared to its laparoscopic counterpart. Further evolution of robotic technology and experience may lead to a reduction of costs, especially if the robotic platform is used in an appropriate healthcare setting.

[Laparoscopic resection with complete mesocolic excision for splenic flexure cancer: long-term follow-up data from a multicenter retrospective study](#)

2020

Abstract

Background: Splenic flexure cancer (SFC), identified as tumors raised in the distal transverse colon and proximal descending colon, accounts for 2 to 5% of all surgically treated colorectal cancers. Despite the fact that the laparoscopic approach has become the gold standard for many colorectal procedures, it has never been extensively investigated in SFC due to lack of an agreed consensus on the appropriate operative procedure. The aim of this multicenter retrospective study is to evaluate the oncologic value of laparoscopic segmental resection with complete mesocolic excision (CME) for cancer located in the splenic flexure.

Methods: All data of consecutive patients who had undergone laparoscopic resection with CME for SFC from January 2005 to December 2017 at five different tertiary centers were retrospectively analyzed. The Kaplan-Meier (KM) test was used to assess the overall survival (OS) and the disease-free survival (DFS) rates after surgery. Univariate Cox regression was used to explore the association between OS and other independent factors.

Results: Recurrence was observed in 13 (11.6%) patients and a significant association between disease stage and recurrence ($P < 0.001$) was found with a higher proportion of stage IV patients in the recurrence group (46.1% vs. 7.1%). During a median follow-up of 43 months (range 12-149), 13 deaths occurred, all of them due to disease progression. KM curves for all stages showed an estimated survival rate of 51% at 148 months.

Conclusion: Laparoscopic segmental resection with CME appears to be an oncologically safe and effective procedure for treatment of SFC and may be considered as a standard surgical method for elective management of the disease. In the future, routine lymph node mapping could be used to confirm this hypothesis.

[Pooled data analysis of primary ventral \(PVH\) and incisional hernia \(IH\) repair is no more acceptable: results of a systematic review and metanalysis of current literature](#)

2019

Abstract

Purpose: Primary (PVHs) and incisional (IHs) ventral hernias represent a common indication for surgery. Nevertheless, most of the papers presented in literature analyze both types of defect together, thus potentially introducing a bias in the results of interpretation. The purpose of this systematic review and meta-analysis is to highlight the differences between these two entities.

Methods: Methods MEDLINE, Scopus, and Web of Science databases were reviewed to identify studies evaluating the outcomes of both open and laparoscopic repair with mesh of PVHs vs IHs. Search was restricted to English language literature. Risk of bias was assessed with MINORS score. Primary outcome was recurrence, and secondary outcomes were baseline characteristics and intraoperative and postoperative data. Fixed effects model was used unless significant heterogeneity, assessed with the Higgins I square (I²), was encountered.

Results: The search resulted in 783 hits, after screening; 11 retrospective trials were selected including 38,727 patients. Mean MINORS of included trials was 15.2 (range 5-21). The estimated pooled proportion difference for recurrence was - 0.09 (- 0.11; - 0.07) between the two groups in favor of the PVH group. On metanalysis, PVHs were smaller in area and diameters, affected younger and less comorbid patients, and were more frequently singular; the operative time and length of stay was quicker. Other complications did not differ significantly.

Conclusion: Our paper supports the hypothesis that PVH and IH are different conditions with the latter being more challenging to treat. Accordingly, EHS classifications should be adopted systematically as well as pooling data analysis should be no longer performed in clinical trials.

[Achieving the Learning Curve in Laparoscopic Inguinal Hernia Repair by Tapp: A Quality Improvement Study](#)

2019

Abstract

Background: More than 20 million patients worldwide undergo groin hernia repair annually. Every year more than 800,000 inguinal hernia repairs are performed in the United States alone. Since the first report by Ger et al. in 1990, laparoscopic inguinal hernia repair has gained wide acceptance due to its many advantages with more than 20% of inguinal hernias treated by this approach. The aim of our study is to estimate the number of cases needed over the course of a trainee's learning curve period to achieve stabilization of operating time and intra and post-operative complication rates when performing laparoscopic transabdominal preperitoneal hernia repair (TAPP). **Methods:** We analyzed data from the first 100 TAPP procedures performed by two different trainees (trainee A & B) and compared it with a homogeneous group of 100 procedures performed by a senior surgeon. Two tests were used to evaluate completion of the learning curve: the Cumulative Sum (CUSUM) and KPSS tests. The CUSUM test evaluated when the trainee's operative time became consistently similar to that of the senior surgeon, while the KPSS test evaluated when the trainee's operative time became stationary. **Results:** No differences in intra and post-operative data were noted between the three groups. The CUSUM test showed that trainee A completed his learning curve after 60 procedures, while trainee B completed it after 65 procedures. The KPSS test showed that the operative time stabilized after 20 procedures for trainee A and after 50 procedures for trainee B, respectively. **Conclusions:** Our evaluation shows that both trainees fully completed their learning curves for the TAPP after 65 procedures, providing us with a parameter which can be taken into consideration when establishing the minimum volume necessary to guarantee correct training in laparoscopic inguinal hernia repair by a TAPP technique.

[Is Shouldice the best NON-MESH inguinal hernia repair technique? A systematic review and network metanalysis of randomized controlled trials comparing Shouldice and Desarda](#)

2019

Abstract

Background: Current guidelines state that the Shouldice technique has lower recurrence rates than other suture repairs and therefore is strongly recommended in non-mesh inguinal hernia repair. Recently a new tissue repair technique has been proposed by Desarda and studied in trials against Lichtenstein technique.

Methods: The present study was performed according to the PRISMA Statement for Network Meta-analysis and the AMSTAR 2 checklist. The method of network meta-analysis was chosen to evaluate randomized controlled trial published on tissue repair and comparing Lichtenstein respectively with Desarda and Shouldice techniques. The following parameters: operative time, recurrence, complications (general, intraoperative, Surgical Site Occurrences), VAS score on postoperative day 1, numbness, chronic pain and return to daily activities.

Results: Fourteen RCTs, involving 2791 patients, fulfilled the inclusion criteria and were selected for final analysis. The anchored indirect treatment comparison showed that Desarda's technique requires a significantly shorter operative time (MD: -12.9 min; 95% CI: -20.6 to -5.2) and has a quicker recovery (MD: -6.6 days; 95% CI: -11.7 to -1.4). Outcomes concerning intraoperative complications, early postoperative pain, seroma/hematoma, hydrocele and infection rates, recurrence, numbness and chronic pain were similar among the two techniques.

Conclusions: Desarda's hernia repair can be a valuable alternative to Shouldice technique for the treatment of primary inguinal hernia repair if a non-mesh technique is chosen, because of its reproducibility and quicker postoperative recovery. We recommend performing well designed prospective studies comparing both techniques directly.

[Lack of advantages of slit mesh placement during laparoscopic transabdominal preperitoneal inguinal hernia repair \(TAPP\): a single centre, case matched study](#)

2018

Abstract

Background: During laparoscopic trans-abdominal pre-peritoneal hernia repair (TAPP) the positioning of the mesh around the spermatic cord could provide an additional anchoring point and ensure better defect closure, thereby preventing mesh movement and recurrence. The primary aim of our retrospective study was to determine if, during a TAPP procedure, an advantageous difference for mesh placement exists between the slit and the non-slit techniques in terms of recurrence rate. Secondary aims were intra and post-operative complications and the time required to return to normal activity.

Methods: From January 2010 to December 2015, data from patients who had undergone TAPPs at our Institution were prospectively collected. We performed a retrospective case control matched study of two homogenous (BMI, Age, type of hernia) groups of 100 patients who underwent respectively TAPP with no slit mesh placement (Group NS) and slit mesh placement (Group S). Statistical analysis was carried out using a SPSS 20. To compare continuous variables, an independent sample T-test was performed. A Chi-square test was employed for categorical data.

Results: No differences were found between the slit and non-slit groups in terms of biometric features and intra and post-operative outcomes were found to be similar in both groups as well. In particular, at mean follow-up of 57.34 ± 10.56 months for Group NS and 55.66 ± 8.61 months for Group S months only one recurrence per group was found.

Conclusion: Our study failed to prove a superiority of the slit mesh technique over the no-slit mesh technique during TAPP. However, in light of its not being a randomized study, a subsequent, well-designed RCT would be desirable in order to better determine if the Slit mesh technique could prove to be advantageous enough to justify its routine use during the TAPP procedure.

[Predictive factors for anastomotic leakage after laparoscopic colorectal surgery](#) 2018

Abstract

Every colorectal surgeon during his or her career is faced with anastomotic leakage (AL); one of the most dreaded complications following any type of gastrointestinal anastomosis due to increased risk of morbidity, mortality, overall impact on functional and oncologic outcome and drainage on hospital resources. In order to understand and give an overview of the AL risk factors in laparoscopic colorectal surgery, we carried out a careful review of the existing literature on this topic and found several different definitions of AL which leads us to believe that the lack of a consensual, standard definition can partly explain the considerable variations in reported rates of AL in clinical studies. Colorectal leak rates have been found to vary depending on the anatomic location of the anastomosis with reported incidence rates ranging from 0 to 20%, while the laparoscopic approach to colorectal resections has not yet been associated with a significant reduction in AL incidence. As well, numerous risk factors, though identified, lack unanimous recognition amongst researchers. For example, the majority of papers describe the risk factors for left-sided anastomosis, the principal risk being male sex and lower anastomosis, while little data exists defining AL risk factors in a right colectomy. Also, gut microbioma is gaining an emerging role as potential risk factor for leakage.

[Defining the characteristics of certified hernia centers in Italy: The Italian society of hernia and abdominal wall surgery workgroup consensus on systematic reviews of the best available evidences](#)

2018

Abstract

Background: The terms "Hernia Center" (HC) and Hernia Surgeon" (HS) have gained more and more popularity in recent years. Nevertheless, there is lack of protocols and methods for certification of their activities and results. The Italian Society of Hernia and Abdominal Wall Surgery proposes a method for different levels of certification.

Methods: The national board created a commission, with the task to define principles and structure of an accreditation program. The discussion of each topic was preceded by a Systematic Review, according to PRISMA Guidelines and Methodology. In case of lack or inadequate data from literature, the parameter was fixed through a Commission discussion.

Results: The Commission defined a certification process including: "FLC - First level Certification": restricted to single surgeon, it is given under request and proof of a formal completion of the learning curve process for the basic procedures and an adequate year volume of operations. "Second level certification": Referral Center for Abdominal Wall Surgery. It is a public or private structure run by at least two already certified and confirmed FLC surgeons. "Third level certification": High Specialization Center for Abdominal Wall Surgery. It is a public or private structure, already confirmed as Referral Centers, run by at least three surgeons (two certified and confirmed with FLC and one research fellow in abdominal wall surgery). Both levels of certification have to meet the Surgical Requirements and facilities criteria fixed by the Commission.

Conclusion: The creation of different types of Hernia Centers is directed to create two different entities offering the same surgical quality with separate mission: the Referral Center being more dedicated to clinical and surgical activity and High Specialization Centers being more directed to scientific tasks.

[The Use of Barbed Suture for Intracorporeal Mechanical Anastomosis During a Totally Laparoscopic Right Colectomy: Is It Safe? A Retrospective Nonrandomized Comparative Multicenter Study](#)

2018

Abstract

Background: A totally laparoscopic right colectomy could be perceived as a more challenging procedure over a laparoscopic-assisted right colectomy owing to the difficulty of intracorporeal anastomosis and the closure of the

enterotomy. The aim of this study is to evaluate the safety and efficacy of the barbed auto-locking absorbable suture for the closure of an anastomotic stapler-access enterotomy during a totally laparoscopic right colectomy.

Methods: From January 2010 to April 2016, data from patients who had undergone a laparoscopic right colectomy in 2 different departments of 2 institutions (the Department of General and Minimally Invasive Surgery, San Camillo Hospital in Trento and the Department of Surgical Specialties and Nephrology, University Federico II in Naples) were retrospectively analyzed. We compared the data of patients in whom the stapler-access enterotomy was closed through a conventional absorbable suture (Group A), with the data of patients in whom a stapler-access enterotomy was closed through a V-Loc 180 suture (Group B). Biometric features and intraoperative and postoperative data were collected and analyzed.

Results: The 2 groups (Group A: 40 patients; Group B: 40 patients) were comparable for biometric features and postoperative outcomes. The anastomosing time was lower in Group B. A statistically significant difference was noted in the mean operative time between Groups A and B (Group A = 134.92 ± 34.17 ; Group B = 120.92 ± 23.27 , $P = .035$). Only one anastomotic leakage per group was recorded, each treated with an anastomosis redo. During the reoperations, we find in both groups an intact stapler-access enterotomy.

Conclusion: On retrospective analysis, barbed suture appears to be safe and efficient for closure of the stapler-access enterotomy during totally laparoscopic right colectomy.

[Laparoscopic recurrent inguinal hernia repair during the learning curve: it can be done?](#) 2017

Abstract

Aim: Trans-Abdominal Preperitoneal Patch (TAPP) repairs for Recurrent Hernia (RH) is a technically demanding procedure. It has to be performed only by surgeons with extensive experience in the laparoscopic approach. The purpose of this study is to evaluate the surgical safety and the efficacy of TAPP for RH performed in a tutoring program by surgeons in practice (SP).

Material and study: All TAPP repairs for RH performed by the same surgical team have been included in the study. We have evaluated the results of three SP during their learning curve in a tutoring program. Then these results have been compared to those of a highly experienced laparoscopic surgeon (Benchmark).

Results: A total of 530 TAPP repairs have been performed. Among these, 83 TAPP have been executed for RH, of which 43 by the Benchmark and 40 by the SP. When we have compared the outcomes of the Benchmark with those of SP, no significant difference has been observed about morbidity and recurrence while the operative time has been significantly longer for the SP. No intraoperative complications have occurred.

Discussion: International guidelines urge that TAPP repair for RH has to be performed only by surgeons with extensive experience in the laparoscopic approach. The results of the present study demonstrate that TAPP for RH could be performed also by surgeons in training during a learning program.

Conclusions: We retain that an adequate tutoring program could lead a surgeon in practice to perform more complex hernia procedures without jeopardizing patient safety throughout the learning curve period.

[Laparoscopic treatment of abdominal unicentric castleman's disease: a case report and literature review](#)

2017

Abstract

Background: Castleman's disease is a rare lymphoproliferative disorder of unknown etiology that most commonly presents as a mediastinal nodal mass. It is exceptionally uncommon for Castleman's disease to present in the mesentery and, only 53 cases have ever been described in the literature. Standard treatment for this lymphoproliferative disorder involving a single node is a complete "en bloc" surgical resection which has proven to be a curative approach in almost all cases without recurrence after 20 years of follow up. All 53 reported cases of mesenteric Castleman's disease, except one, were treated with laparotomy.

Case presentation: We report on a case of mesenteric Castleman's disease localized in the mesentery which is the second reported case of its kind and was treated by a laparoscopic-assisted procedure. Our female patient had an uneventful postoperative course and was discharged in the 5th post-operative day. No signs of recurrence were present as evidenced by physical examination and total body CT scan 24 months after the operation. We compare our case with the other reported cases in which Castleman's disease presented as an isolated mass in the abdomen.

Conclusion: Although a rare disease, Unicentric Castleman's disease should always be considered when a solid asymptomatic abdominal mass is occasionally presented. The laparoscopic approach (LA) allows for the achievement of better results than open surgery, including a reduction in postoperative pain and length of hospital stay. In cases of masses of an uncertain nature, LA must be considered the last diagnostic tool and the first treatment one.

[Reply to Early colon cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up](#) 2016

[Simultaneous abdominal wall defect repair and Tenckhoff catheter placement in candidates for peritoneal dialysis](#)

2016

Abstract

Introduction: The presence of pre-existing abdominal wall defect (AWD) could represent a potential contraindication for peritoneal dialysis (PD) treatment. We report the results of our 6-year experience involving simultaneous repair of pre-existing AWD and catheter insertion for PD.

Methods: Patients with estimated glomerular filtration rate (e-GFR) 7-10 ml/min attending a single nephrology clinic between January 2008 and December 2014 were evaluated. Simultaneous AWD repair and catheter placement was performed. For inguinal (IH) or umbilical hernia (UH), a prolene mesh repair technique was adopted. Except for one case of total anaesthesia, the surgical procedure was performed under either spinal or local anaesthesia. Ceftazidime alone or in association with quinolones was administered 1 h before surgery in a single dose. Patients were discharged 2 days after surgery, and returned to the clinic twice during the 1st week for peritoneum washing (first volume of peritoneal dialysis solution: 300 ml). From week 3, volume (2000 ml) and dwells were personalized

according to the patient's clinical condition; options were: incremental PD, standard PD, or continuous cycling PD. Surgical follow-up was planned at 1, 6, and 12 months.

Results: Peritoneal catheters were inserted in 170 patients. IH, UH and incisional hernia were found in 18, 2 and 1 patients, respectively. IH was bilateral in 4 patients; concomitant IH and UH occurred in 1 patient. There were no deaths, nor intra-operative complications apart from scrotal haematoma in 1 patient. Over a mean follow-up of 551 days (range 342-1274) no hernia recurrence was registered and the peritoneal catheter continued functioning without problems.

Conclusions: Simultaneous AWD repair and peritoneal catheter placement seems a reliable and safe surgical procedure that allows patients with AWD to benefit from PD treatment.

Emergency endovascular management of the common femoral artery rupture due to radiotherapy for scrotal carcinoma

2015

Abstract

We describe the case of a 72-year-old man with massive hemorrhage and shock resulting from rupture of the left common femoral artery as a complication of radiotherapy in the groin for cancer of the scrotum. This complication is extremely rare, presents dramatically, and is usually fatal. The patient was successfully treated with a stent graft deployment in order to achieve immediate hemostasis maintaining blood flow to the leg. Open surgery is not ideal in those cases especially when there is extensive tumor involvement of the groin causing altered anatomy and increasing the risk of re-bleeding.

Multidisciplinary diagnostic approach combining fine needle aspiration, core needle biopsy and imaging features of a presacral myelolipoma in a patient with concurrent breast cancer

2015

Abstract

Myelolipomas are uncommon benign tumors composed of mature adipose tissue mixed with hematopoietic elements; these tumors can occur in both the adrenal glands and extra-adrenal locations, the presacral region being the most frequent extra-adrenal site. We present a case of presacral myelolipoma diagnosed by fine needle aspiration (FNA) and core needle biopsy (CNB) in a 55-year-old woman with concurrent invasive ductal breast cancer. TC and RM imaging were consistent with the diagnosis of presacral myelolipoma. The lesion was discovered incidentally during the staging procedure for breast malignancy. The purpose of our work is to describe the FNA and CNB finding in combination with the imaging features of this uncommon lesion.

DOI: 10.1016/j.prp.2014.12.004

Beneficial effects of fibrin glue (Quixil) versus Lichtenstein conventional technique in inguinal hernia repair: a randomized clinical trial

2014

Abstract

Introduction: In inguinal hernia repair, many complications are due to mesh fixation technique. Therefore, new types of atraumatic methods of fixation have been proposed. In this article, we present the results of a prospective multicentric parallel randomized controlled trial aiming to compare two mesh fixation techniques: fibrin sealant (QUIXIL®), Omrix Biopharmaceuticals S.A., Belgium) and Lichtenstein technique.

Method: Adult patients with primary uncomplicated inguinal hernia were randomized in two groups: fibrin sealant group (FSG) and Lichtenstein group (LTG). The two groups underwent a follow-up of 15 months. Operative time is the primary outcome. Intraoperative and postoperative outcomes were analyzed. Moreover, a differential cost analysis was performed. Patients and evaluators (with exception of the surgeon who treated the patient) were blinded.

Results: A total of 102 patients, 50 in FSG and 52 in LTG, were enrolled from January 2009 to June 2010, and two patients were lost to follow-up at the twelfth month. No significant differences in baseline and clinical characteristics were observed in the two groups. Operative time was longer in LTG (median/ interquartile range: 35 min/30-42.5 min vs. 31 min/28-35 min; effect size: 0.65/95% CI 0.50-0.91; $p < 0.05$). No differences in intraoperative complications were observed. No significant differences were observed in early complication rate (RR = 0.62; $p > 0.05$). Numbness rate was lower in the FSG at 1 week (RR = 0.43; $p < 0.01$) and at 1 month (RR = 0.17; $p < 0.05$). No significant differences were observed after 6 months. Postoperative pain was lower in the FSG at 1 week (0/0-1 vs. 1/0-2; $p < 0.05$) and at 1 month (0/0-0 vs. 0/0-1; $p < 0.05$). Pain disappeared in all patients after 6 months. Analgesic assumption rate was lower in the FSG (RR = 0.42; $p < 0.05$). Twenty per cent of FSG and 9.62% of LTG patients were discharged within 12 h; 78% of FSG and 90.38% of LTG patients were discharged within 24 h. The only one recurrence we observed was in FSG group. About costs, although fibrin sealant needed for one mesh fixation is about 10 times more costly than the needed sutures, the total costs of the two procedures did not change significantly. This was mainly due to reduction in operative time.

Conclusions: The use of fibrin sealant determined a significant reduction in short-term numbness rate and postoperative pain. There was no relevant difference in total costs per patient between the two procedures.

[Single access laparoscopic left hemicolectomy with or without inferior mesenteric artery preservation: our preliminary experience](#)

2013

Abstract

Aim: We report our preliminary experience in single access laparoscopic left hemicolectomy (SALLH) with or without inferior mesenteric artery preservation, showing the results of a selected group of patients.

Methods: This retrospective case series enclosed all patients operated between October 2009 and June 2012 of a left hemicolectomy with single laparoscopic access for benign and malignant diseases. The mean follow-up was 18 months. Intraoperative and postoperative results were recorded.

Results: This retrospective case series enclosed 24 patients. Mean operative time was 157.8 min. The mean final skin incision length was 3.65 cm. All operations were completed by a single access laparoscopic approach. There were no conversion or intraoperative mortality. There were no required any intraoperative blood transfusion. Only three cases of postoperative complication were registered. The mean flatus canalization was two days. The mean discharge time was seven days. At a mean 18-month follow-up there were no incisional hernia or deaths.

Conclusion: As best of our knowledge, we report one of the largest experience gained in Italy about SALLH. We think that although SALC could be safe and feasible, it cannot be considered as a "new standard" procedure used by anyone. In contrast we retain that it is mandatory that SALC continued to be evaluated into larger multicentric RCT.

PMID: 23774097

[Spleen rupture: an unusual postoperative complication after laparoscopic cholecystectomy](#) 2013

Abstract

Introduction: Laparoscopic cholecystectomy is the gold standard in the surgical treatment of symptomatic cholelithiasis and other benign gallbladder diseases. Laparoscopic cholecystectomy isn't devoid by some complications such as intra and post-operative bleeding, biliary injury, bile leakage, surgical site infection, port-site hernia and visceral injury. After an extensive literature research, we find only one case study in which the patients required a splenectomy after laparoscopic cholecystectomy. We present a case of uneventful laparoscopic cholecystectomy requiring an open splenectomy during the postoperative course.

Case report: The Authors report a case of ruptured spleen during the second post-operative day after an uncomplicated laparoscopic cholecystectomy. At 36 hours after the operation, the patient referred a sudden upper abdominal pain. We performed a splenectomy, intra-abdominal lavage and two drainages have been placed. The patient was discharged in the 7th post-operative day in good clinical condition.

Conclusion: As best of our Knowledge we report the second case of spleen rupture after a cholecystectomy, which is reported in the literature. We think that the splenic injury should not be due to direct trauma after or at the time of cholecystectomy, but it should be due to some adhesions stretched by the pneumoperitoneum induction.

PMID: 23694944

[Which is the best laparoscopic approach for inguinal hernia repair: TEP or TAPP? A systematic review of the literature with a network meta-analysis](#)

2012

Abstract

Background: Totally extraperitoneal (TEP) repair and transabdominal preperitoneal (TAPP) repair are the most used laparoscopic techniques for inguinal hernia treatment. However, many studies have shown that laparoscopic hernia repair compared with open hernia repair (OHR) may offer less pain and shorter convalescence. Few studies compared the clinical efficacy between TEP and TAPP technique. The purpose of this study is to provide a comparison between TEP and TAPP for inguinal hernia repair to show the best approach.

Methods: We performed an indirect comparison between TEP and TAPP techniques by considering only randomized, controlled trials comparing TEP with OHR and TAPP with OHR in a network meta-analysis. We considered the following outcomes: operative time, postoperative complications, hospital stay, postoperative pain, time to return to work, and recurrences.

Results: The two techniques improved some short outcomes (such as time to return to work) with respect to OHR. In the network meta-analysis, TEP and TAPP were equivalent for operative time, postoperative complications, postoperative pain, time to return to work, and recurrences, whereas TAPP was associated with a slightly longer hospital stay compared with TEP.

Conclusions: TEP and TAPP improved clinical outcomes compared with OHR, but the network meta-analysis showed that TEP and TAPP efficacy is equivalent. TAPP was associated with a slightly longer hospital stay compared with TEP.

Progetti

15/11/2019

LaGaFu Co-Investigator del centro Principale AUOP Federico II di Napoli per lo studio LaGaFu

15/11/2019

ESIRAMI Co-Investigator del centro Principale AUOP Federico II di Napoli per lo studio ESIRAMI

15/11/2019

IgOMIPS Investigator del centro Satellite AUOP Federico II di Napoli per lo studio IgOMIPS

01/05/2019

LaRoTa Co-Investigator del Centro Principale AUOP Federico II di Napoli per lo studio LaRoTa

01/05/2019

CircOnco Co-Investigator del Centro Principale AUOP Federico II di Napoli per lo studio CircOnco

01/11/2018

Membro del Gruppo Nazionale di Studio sulla Qualità in Chirurgia della Parete Addominale Membro del Gruppo Nazionale di Studio sulla Qualità in Chirurgia della Parete Addominale che svilupperà il sistema di accreditamento degli Hernia Center (ISHAWS), pubblicato su Int. J. of Surgery "Defining the characteristics of certified hernia centers in Italy: The Italian society of hernia and abdominal wall surgery workgroup consensus on systematic reviews of the best available evidences.

10/06/2013

LABOR Co-Investigator del Centro Satellite AUOP Federico II di Napoli per lo Studio Prospettico Randomizzato LABOR (LAparoscopic Bridging versus anatomic Open Reconstruction for midline abdominal hernia mesh repair)

01/01/2011

Quixil Co-investigator del Centro principale AUOP Federico II di Napoli per lo Studio Prospettico Randomizzato Multicentrico "Beneficial effects of fibrin glue (Quixil) versus Lichtenstein conventional technique in inguinal hernia repair: a randomized clinical trial."

Onorificenze e riconoscimenti

06/12/2019 ISHAWS

Premio Best Video Awards Under 40 Vincitore del Premio Best Video Awards Under 40 durante il Congresso Nazionale ISHAWS tenutosi a Napoli il 5-6 Dicembre 2019

Competenze comunicative e interpersonali

Competenze comunicative e interpersonali La comprensione, l'empatia, la volontà di lavorare in team e di collaborare sono doti che mi contraddistinguono da sempre. Con l'esperienza dapprima come specializzando e poi come medico volontario presso le Unità Operative Complesse di Chirurgia Generale di diversi Ospedali Italiani, sono riuscito a migliorare ulteriormente queste mie capacità innate, potenziando in particolar modo quelle collaborative grazie al lavoro nei team multidisciplinari.

Partecipazione a Master e Corsi di Perfezionamento

01/09/2022 – 16/12/2022

Scuola U Parini di Chirurgia Bariatrica Congiunta ACOI SICOB

Corso di formazione residenziale congiunto tra le società ACOI e SICOB per il perfezionamento in chirurgia bariatrica

01/01/2022 – 26/10/2022

Master in Management delle aziende sanitarie

Master in Management delle Aziende Sanitarie ottenuto con votazione 29/30

23/09/2019 – 24/09/2019

Chirurgia Bariatrica per Team Multidisciplinare

05/06/2018 – 08/06/2018

Corso Base di Chirurgia Robotica

Partecipazione al Master "Corso Base di Chirurgia Robotica" tenutosi presso l'Ospedale Civile di Grosseto.

05/06/2017 – 08/06/2017

Corso base di chirurgia robotica

organizzato dalla Robotic School - Grosseto (50 ECM)

17/02/2016 – 20/02/2016

Corso teorico pratico Master di I livello" organizzato dalla Italian Society of Hernia and Abdominal Wall Surgery (ISHAWS)

Competenze Professionali

Competenze Professionali

01/04/2019 ad oggi - Durante il periodo come volontario presso il Dipartimento di Gastroenterologia, Endocrinologia e Chirurgia Endoscopica della AUOP Federico II di Napoli, diretto dal Prof. G.D. De Palma e supervisionato dal Prof. U. Bracale ho approfondito e sviluppato non solo le indicazioni e le tecniche di chirurgia laparoscopica avanzata, ma anche numerose tematiche di ricerca scientifica, con particolare interesse per la patologia neoplastica dell'apparato gastro-enterico e la patologia della parete addominale.

01/10/2018 ad oggi - Durante il periodo come Dirigente Medico di Primo livello presso l'Ospedale San Giovanni di Dio di Frattamaggiore NA, UOC di Chirurgia Generale e Laparoscopica diretta dal Dott. Michele Perrotta, ho avuto modo di sviluppare ed approfondire le indicazioni e le tecniche di chirurgia d'urgenza e di Chirurgia Bariatrica di cui sono il responsabile

05/03/2018 al 30/09/2018 - Durante il periodo come libero professionista presso la Casa di Cura Villa Berica sotto la supervisione del Prof. G. Pignata ho continuato ad approfondire le indicazioni e le tecniche in chirurgia laparoscopica con particolare interesse per la chirurgia della parete addominale, bariatrica e colo-rettale.

24/07/2017 al 28/02/2018 - Durante il periodo come assistente volontario presso la UOC di Chirurgia Generale e Mininvasiva dell'Ospedale San Camillo di Trento, diretta dal Prof. G. Pignata ho continuato ad approfondire le indicazioni e le tecniche di chirurgia laparoscopica, con particolare interesse per la chirurgia della parete addominale, chirurgia bariatrica e colo-rettale.

01/01/2016 al 30/06/2017 - Durante il periodo di formazione svolto presso la UOC di Chirurgia Generale e Mininvasiva dell'Ospedale San Camillo di Trento, diretta dal Prof. G. Pignata ho approfondito le indicazioni e le tecniche di chirurgia laparoscopica. In particolar modo nei settori della chirurgia bariatrica, chirurgia della parete addominale e chirurgia colo-rettale.

01/11/2015 al 30/12/2015 - Durante il periodo di formazione svolto presso la UOC diretta dal Dott. De Palma presso l'AORN Cardarelli di Napoli ho approfondito le indicazioni e le tecniche chirurgiche di endocrino-chirurgia.

04/07/2012 al 04/07/2017 - Durante il periodo di formazione svolto presso la UOC di Chirurgia Generale e del Pre e Post Trapianto diretta dal Prof. E. Di Salvo ho approfondito le indicazioni e le tecniche chirurgiche di Chirurgia Generale addominale ed in particolare la loro applicazione e successiva gestione nei pazienti già sottoposti a trapianto. Sono state in particolar modo approfondite le tecniche di chirurgia laparoscopica del colon-retto e della parete addominale.

Competenze informatiche

Sistemi operativi

OsX: Ottima Conoscenza
Windows: Ottima Conoscenza
Ubuntu: Buona Conoscenza

Suite Microsoft Office

Microsoft Word: Ottima Conoscenza
Microsoft Power Point: Ottima Conoscenza
Microsoft Excel: Ottima Conoscenza

Programmi di editing video e gestione delle immagini

Adobe Photoshop: Buona Conoscenza
Adobe After Effects: Buona Conoscenza
Final Cut Pro: Ottima Conoscenza
Suite Pinnacle: Buona Conoscenza

Programmi di statistica ed analisi dati

IBM SPSS: Buona Conoscenza
GraphPad Prism: Buona Conoscenza
XLstat: Buona Conoscenza

Attestato delle competenze digitali nel corso organizzato da: Eccellenze digitali di Google.

Partecipazione a corsi in qualità di chirurgo operatore/aiuto

22/11/2019

La formazione in chirurgia laparoscopica del colon retto: dall'anatomia alla standardizzazione

AUOP Federico II di Napoli -> I Aiuto

29/05/2019

Scuola di Riferimento Nazionale SIC di Chirurgia Laparoscopica Avanzata

AUOP Federico II di Napoli -> I Aiuto.

06/06/2018

Scuola di Riferimento Nazionale SIC di Chirurgia Laparoscopica Avanzata

Ospedale Monaldi di Napoli -> I Aiuto.

28/11/2017

Corso EXPLORING LAPAROSCOPIC SURGERY: Use of laparoscopic staplers;

Ospedale San Camillo di Trento -> Assistente al campo operatorio

28/11/2017

Corso EXPLORING LAPAROSCOPIC SURGERY: Use of laparoscopic staplers

Ospedale San Camillo di Trento -> I Aiuto

Indicatori Biometrici

Indicatori Biometrici 2022

- Codice OrcID:0000-0002-3237-677X
 - Scopus Author ID: 55250088200
 - Numero totale di pubblicazioni su rivista (PubMed): 22
 - H-index (Scopus): 7
 - Numero totale di citazioni (Scopus): 192
 - H-index (GoogleScholar): 9
 - Numero totale di citazioni (GoogleScholar): 340
 - Numero totale di articoli negli ultimi 5 anni: 14
 - Capitoli in libri: 7
- Mediane di riferimento per Professore di II fascia settore Chirurgia Generale 06/C1:
- H-index: 7 (Raggiunto)
 - Numero di citazioni negli ultimi 10 anni: 158 (Raggiunto)
 - Numero di articoli negli ultimi 5 anni: 9 (Raggiunto)

Pubblicazioni a stampa su Libri e CD

Pubblicazioni a stampa su Libri e CD

- Abdominal Wall Surgery How Reimbursement Systems Can Change Surgical Evolution
Editors: Greco, Dalila Patrizia, Borgonovi, Elio
- Chapter 16: Present and future of EBM in Inguinal Hernia Repair and Abdominal wall reconstruction
- Manuale di Chirurgia
Editors: Parmeggiani - Agresti - Amato - Conzo - Di Salvo
- Capitolo 8: La chirurgia mininvasiva
- Laparoscopic Surgery Key Points, Operating Room Setup and Equipment
Editors: G. Pignata, U. Bracale, F. Lazzara
- Chapter 2: Liver, Gallbladder, and Biliary Tree
- Chapter 1: Esophagus and Stomach
- Single-Access Laparoscopic Surgery Current Applications and Controversies
Editors: G. Pignata, F. Corcione, U. Bracale
- Chapter 9: Single-Access Laparoscopic Left Hemicolectomy
- Gastric Cancer: From Staging to Surgical Treatment. Procedures, Complications and Oncological Results
Editors: A. D'Annibale, V. Pende and I. Monsellato
- Chapter 6: Laparoscopic Total and Subtotal Gastrectomy for Gastric Cancer

Abstract in Rivista

Abstract in Rivista

- U Bracale; P Nastro; G Merola; G Pignata Single Access laparoscopic left hemicolectomy for benign disease: a preliminary experience Ospedali d'Italia. Chirurgia 2011
- U Bracale; P Nastro; M; G Merola; G Pignata Single Incision laparoscopic colorectal surgery: preliminary results Colorectal Disease 2011
- T Strazzullo, G Prestieri, D Di Simone, G Merola The Tenckhoff catheter in elderly patients with chronic renal failure: placement in spinal anesthesia with open technique, without required location in the hollow of Douglas BMC Geriatrics 2011, 11(Suppl 1):A61
- B Scotto, E Spera, G Merola, D Di Simone Lynch II syndrome: a case report BMC Geriatrics

Segreteria Scientifica

10/12/2019

LA CHIRURGIA OLTRE LA TECNICA. WEEK SURGERY E DINTORNI

Golden Tulip Caserta

16/04/2019

CRITICITA' MEDICO-CHIRURGICHE IN TEMA DI CANCRO COLORETTALE.

Aula Magna Scuola Nazionale di Amministrazione, Caserta. Italia

12/10/2018

INCONTRO MULTIDISCIPLINARE: LA GESTIONE DEL NODULO TIROIDEO.

Ospedale San Giovanni di Dio. Frattamaggiore. Italia

06/12/2016

EXPERT PANEL - APPROCCIO CRITICO ALLA PATOLOGIA DELL'ERNIA E DELLA PARETE ADDOMINALE

Ospedale San Camillo. Trento. Italia

Appartenenza a Gruppi / Associazioni

Appartenenza a gruppi / associazioni

Regolarmente iscritto alle seguenti Società Scientifiche:

- Società chirurgica Terra di Lavoro Componente del consiglio direttivo in qualità di Revisore dei conti.
- Società Italiana di Chirurgia dell'Ernia e della Parete Addominale (ISHAWS) Socio
- European Society of Medical Oncology (ESMO) Socio
- Società Italiana di Chirurgia Endoscopica (SICE) Socio
- Associazione Chirurgi Ospedalieri Italiani (ACOI) Socio
- Società Italiana di Chirurgia dell'Obesità (SICOB) Socio
- International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) Socio
- European Association of Endoscopic Surgeon (EAES) Socio

Autorizzo il trattamento dei miei dati personali presenti nel CV ai sensi dell'art. 13 d. lgs. 30 giugno 2003 n. 196 - "Codice in materia di protezione dei dati personali" e dell'art. 13 GDPR 679/16 - "Regolamento europeo sulla protezione dei dati personali".

Napoli, 24/05/2023

