2021 Scientific Session of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), Las Vegas, Nevada, 31 August–3 September 2021: Video Loops

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V108

Robotic Revision of Gastro-Gastric Fistula Due to Marginal Ulcer to Gastric Bypass

Ramon Vilallonga, PhD; Enric Caubet; Berta Parés; Amador García; Meritxell Pera; Beisani Marc; Elsa García; Oscar Gonzalez; Juan Camilo Vivas; Jose Manuel Fort; Manel Armengol; Vall Hebron Hospital

We herein present the clinical case of a 61-year-old male patient with a laparoscopic gastric bypass in 2013 (BMI 47.23 kg/m²). Patient presented chronic epigastric pain followed with marginal ulcer treated conservatively. Persistent pain and study revealed a gastro-gastric fistula from gastric pouch and remanent stomach. An esophageal-gastro-duodenal transit confirming high-output gastro-gastric fistula and hiatal hernia. This video aims to describe the technical steps to resect an anastomotic ulcer and convert the gastro-gastric fistula included in the ulcer to a novel gastric bypass. Robotic technology is used in this case to facilitate hiatoplasty, pouch resizing and ulcer resection.

V109

A Modified Laparoscopic Hepatic Flexure Mobilization for Simple Vascularized Omental Pedicle Flap in Complex Crohn’s Disease

Patricio B Lynn, MD1; Mohamad H Abouzeid, MD, FACS2; David M Schwartzberg, MD, FACS2; 1NYU Langone Health; 2Mather Hospital-Northwell Health

A laparoscopic ileocolic resection for Crohn’s disease can be performed to remove the diseased bowel. If the anastomosis is near the duodenum, it is recommended that a vascularized omental flap is positioned between the anastomosis and the duodenum. Typically, the omentum is taken off the colon during laparoscopic hepatic flexure mobilization, however the omentum then needs to be located for the flap. A modified hepatic flexure mobilization, where the colon and omentum are mobilized from the hepatic flexure allows a simple & facile vascularized flap as the omentum can be exteriorized with the bowel and used to cover the anastomosis.
V110

A Rare Case of Small Bowel Obstruction Caused by Gastric Band Migration

Enrique Arias Ramirez, MD; Carlos Rodriguez Albanez, MD; Otto Montoya, MD; Hospital Nacional Rosales; Obesity El Salvador

The patient is a 57 years old man with a 6 months history of nausea, weight loss and fullness sensation, 2 weeks of colicky upper abdominal pain, vomiting and oral intolerance to solid food; he had a gastric banding as bariatric procedure 16 years prior, and adjustment port site infection 6 years ago. X-ray and CT scan show gastric and proximal small bowel dilation, and the band located at the left lower quadrant of the abdomen. A diagnostic laparoscopy was performed using intraoperative X-ray helping to find the specific band location, it was found at the first 60 cm of jejunum.

V112

Robotic SADI Limb Length Modification

Samuel Jankey; Walter Medlin, MD, FACS; Daniel Cottam, MD; Christina Richards, MD, FACS; Amit Surve, MD; Legrand Belnap, MD; Bariatric Medicine Institute.

This is a case of a 69-year-old male patient with a body mass index (BMI) of 32.9 kg/m ² who underwent a single-anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) procedure for morbid obesity. The patient experienced chronic diarrhea following SADI-S. Ten months following SADI-S, the patient underwent a common channel lengthening (CCL) procedure for chronic diarrhea. Upon entering the abdomen, the common channel was found to be 250 cm in length. An additional 150 cm of small bowel was added to the common channel using the technique shown in the video.

V111

Prostate Sparing Robotic Assisted Lar

Carla J Newton, MD; Kristofer Wagner, MD; Rahila Essani, MD, FACS; Baylor Scott & White

A 68 y.o. male presented with Stage IIIC moderately differentiated adenocarcinoma of the rectum originally requiring a loop sigmoid colostomy due to obstruction. The mass was found to invade the seminal vesicles and abut the prostate despite neoadjuvant chemotherapy. He underwent prostate sparing robotic assisted LAR with bilateral removal of seminal vesicles. Four robotic ports were used. The loop colostomy was taken down. The LAR was performed with en bloc resection of the bilateral vas deferens, seminal vesicles, base of prostate, and rectum. The colorectal anastomosis was made with a 28 mm EEA stapler and a diverting loop ileostomy was matured.

V113

Laparoscopic Paraesophageal Hernia Repair After Gastric Bypass with Enucleation of Incidental Esophageal Tumor and Myotomy

Monica Polec, MD; Joseph Blankush, MD; Joseph Broucek, MD; Vandybulit University Medical Center

This video presents the case of a 54 year old female with a history of roux-en-y gastric bypass and worsening dysphagia. Manometry, EGD, and CT scan revealed a spastic esophagus as well as a paraesophageal hernia containing remnant stomach. In an effort to reduce her dysphagia which was attributed in part to her paraesophageal hernia, she was taken to the operating room with plan for a laparoscopic paraesophageal hernia repair. At the time of surgery, an incidental esophageal mass was also encountered and enucleated, with pathology revealing a GIST.
V114

Robotic Transanal Minimally Invasive Rectourethral Fistula Repair
Ahmed I Allawi, MBChB, MD; Kevin T Behm, MD; Nimesh D Naik, MD; Boyd R Viers, MD; Scott R Kelley, MD; Mayo Clinic

Purpose/Background: Robotic transanal minimally invasive surgery (R-TAMIS) using the Intuitive Surgical da Vinci Xi platform provides high-definition visualization and multiple degrees of freedom to address rectourethral fistulas (RUF).

Methods/Interventions: An Applied Medical GelPOINT® Path Transanal Access Platform and robotic trocars are placed to gain access. The fistula is dissected and the rectum and urethra are separated. Following excision of the fistula tract the urethra and rectum are closed independently with absorbable suture.

Results/Outcome: No recurrence or major morbidity 10 months from surgery.

Conclusions/Discussion: R-TAMIS provides an incisionless minimally invasive approach for non-irradiated RUF repair.

V116

Delayed Diagnosis of Caecal Adenocarcinoma Due to COVID-19 Presenting as an Ileocolic Intussusception: Laparoscopic Management
Antonio D’urso; Jacques Marescaux; Didier Mutter; Nouvel Hôpital Civil, IRCAD, IHU

This is the case of a 43 years old female patient suffering of abdominal pain and constipation since February 2020. An abdominal sonography was negative. During the following months pain increased progressively but due to the acute phase of Covid19 pandemia in France she didn’t underwent any other further investigation. In September 2020 a colonoscopy showed an occlusive mass of the right colon. Total body CT scan showed an ileo-colic intussusception with small bowel dilation and regional nodes, no distant metastasis. Full laparoscopic right colectomy with central vascular ligation and D2 lymphadenectomy and intraabdominal anastomosis was performed.

V115

Intrathoracic Gastric Volvulus Post Nissen Fundoplication. Revisional Surgery to LRYGB Plus Partial Gastrectomy
Manuel Aceves, MD, FACS; Raul Perez, MD; Eric Barragan, MD, FACS; Natalia Mendoza, MD; 1Obesidad y Laparoscopia Avanzada de Occidente; 2Hospital Civil de Guadalajara; 3IMSS

73 year old male with GERD. Successful laparoscopic floppy Nissen fundoplication was performed. Two months later, presented gastroenteritis, vomiting, suddenly dysphagia, sialorrhea, retrosternal pain. Diagnosis of paraesophageal hernia, intrathoracic migration of fundoplication and gastric volvulus. Laparoscopic revisional surgery, reduction of stomach, fundoplication dismantling, gastric necrosis with perforation. We performed a Roux-en-Y Gastric Bypass plus partial gastrectomy. Acute paraesophageal herniation post fundoplication can be suspected by the history of a precipitating event accompanied by typical symptoms. Conversion of paraesophageal hernia with gastric volvulus and necrosis areas to RYGB is a feasible option. It is a difficult surgery that requires an expert surgeon.

V118

Spleen Preserving Surgery – Open and Laparoscopic Approach
Francesco Crafa, Dr; Serafino Vanella, Dr; Benedetto Neola, Dr; Antonio Miro, Dr; St. Giuseppe Moscati Hospital

Splenectomy is associated with severe perioperative complications. Splenectomized patients are at risk for potentially fatal infections. Partial splenectomy (PS) can remove the lesion and preventing OPSI. We present 2 patients (1 men of 35 years and 1 women of 50 years) underwent open PS for a 16 cm hemo-lymphangioma and laparoscopic PS for hemangioma with spontaneous partial internal rupture. The postoperative course was uneventful.

In high volume centers PS is a safe option and should be preferred for all patients, when indicated. The mini-invasive approach seemed to be feasible.
V119

Laparoscopic Resection for Colo-vesical fistula
Shuichiro Matoba, PhD; Hiroya Kuroyanagi, PhD; Masashi Ueno, PhD; Shigeo Toda, MD; Yutaka Hanaoka; Kosuke Hiramatsu, MD; Yudai Fukui; Toranomon Hospital

Colo-vesical fistula CVF is the most challenging hurdle in fistula associated with diverticulitis.

Methods: Patients who had undergone laparoscopic resection for CVF in our hospital between 2010 and October 2020 were included in this study. We use 5ports, and 10 mm 3D flexible scope to operate.

Results: There were 55 cases of laparoscopic resection for CVF. There were no conversion to open surgery. Median operative time and blood loss was 215 min and 75 ml respectively. There were 2 cases with complications of Clavian-Dindo Grade of greater than III.

Conclusion: Laparoscopic resection for CVF is safe and feasible.

V120

Tandem use of Firefly™ Transillumination and Tile Pro Endoscopy for Identifying and Reversing the Difficult Rectal Stump
Lance Horner, MD; Garrett Friedman, MD; 1University of Nevada Las Vegas School of Medicine, Department of Surgery; 2Mike O'Callaghan Military Medical Center

Identifying the rectal stump during minimally invasive colostomy reversal can prove quite challenging. Here, we demonstrate the use of TilePro Endoscopy and 1:1 palpation, combined with transillumination using Firefly™ Fluorescence imaging during a robotic-assisted laparoscopic colostomy reversal. We also implement our “MIS first” approach whereby the rectal stump is identified and dissected free, the EEA anvil introduced through the intact stoma and the reversal completed in a minimally invasive fashion, prior to excising the residual stoma at the completion of the operation. We have found that implementing these techniques can lead to better success when reversing the difficult colostomy.

V121

Laparoscopic Total Gastrectomy and D2 Lymphadenectomy for Advanced Gastric Cancer with Completely Intracorporeal Anastomoses
Enrique Arias, MD, FACS; Diana Galan, MD; Francisco A Ruiz Zelaya, MD; INTERLAP Centro Internacional de Cirugía Laparoscopica

This video is about a 35-year-old female patient complained of, fullness, nausea, and weight. Endoscopy revealed severe thickening of stomach and biopsy reported a poorly differentiated adenocarcinoma. Abdominal CT Scan showed no mets so routine preop was done and she was scheduled for a Laparoscopic Total Gastrectomy + D2 Lymphadenectomy. Surgery was completely done by laparoscopy, reconstruction of the transit was done in a Roux-en-Y manner, with intracorporeal anastomoses. On the 5th day the feeding tube was removed and we began oral intake. The patient was discharged on the seventh day.

V122

Laparoscopic Total Pelvic Exenteration with Bilateral Pelvic Lymph Node Dissection—Systematic Approach
Swapnil Patel; Vivek Sukumar; Sanket Bankar; Mufaddal Kazi; Ashwin DeSouza; Jitender Rohila; Avanish Saklani; Tata Memorial Centre and Homi Bhabha National University

Minimally invasive approach for pelvic exenterations for locally advanced rectal cancers and recurrent rectal cancers has shown its value in terms of oncological adequacy with equivalent margin negative resection rates, superior perioperative outcomes and improving conversion rates along the learning curve. This is a video illustration of laparoscopic total pelvic exenteration with bilateral pelvic lymph node dissection done for a locally advanced rectal cancer in a 48 year gentleman. Adequate knowledge of the anatomy, especially of the pelvic retroperitoneal spaces and a step-wise systematic approach to the lengthy procedure results in improved intraoperative conduct ensuring oncological adequacy.
V123

Endoscopic Negative Pressure Wound Therapy for Gastric Sleeve Leak

Amy Rosenbluth, MD; Anna Tavakkoli, MD; Carla Holcomb, MD; Sara Hennessy, MD; Benjamin Schneider, MD; Daniel Scott; Stony Brook; UT Southwestern

This video details the endoscopic management of a leak after sleeve gastrectomy. Initial management of this complicated postoperative course began with IR drainage and an endoscopically placed stent. However, the stent migrated and eroded through the gastric wall at the area of the leak. This complication was then successfully managed with endoluminal negative pressure therapy over the course of a month, which is shown in detail within this video. The patient has since been discharged and is doing well at home.

V124

Video Presentation: Laparoscopic Revision of Jejunojejunostomy for Volvulus of Long Roux Limb

Michael T Fastiggi, MD; Joseph M Youssef, DO; Leena Khaitan, MD, MPH; Mujjahid Abbas, MD; Cleveland University Hospitals

Description: The patient is a 27-year-old female that had a gastric bypass in 2014 at an outside institution with excellent weight loss but then developed recurrent epigastric abdominal pain and diarrhea. Imaging showed mesenteric swirling with fecalized bowel contents and the patient was booked for an urgent diagnostic laparoscopy. Intraoperatively she was found to have a 400 cm roux limb with a 50 cm common channel, and the redundancy of the roux limb had caused a volvulus. The bilipancreatic limb was divided and brought proximally to create a 150 cm roux limb and 250 cm common channel. The patient had significantly improved symptoms at follow-up.

V125

Robotic inguinal Hernia Repair of Giant Recurrence Containing Bladder

Katherine T Fay; Ann Defnet; Edward Lin; S. Scott Davis Jr; Emory University.

We present a 67-year-old male with a giant recurrent right inguinal hernia containing significant amounts of bowel and a portion of the bladder. Due to prior operations, the bladder was densely adhered anteriorly to the previously placed mesh plug. In order to improve our visualization and identify a potential injury, we instilled the bladder with methylene blue. Parietene mesh was cut broadly to ensure full coverage of the myopectineal orifice. Postoperatively, the patient developed a scrotal seroma; CT imaging revealed a likely scrotal hematoma with evagination of mesh into the hernia defect without evidence of recurrence.

V126

Robotic-Assisted Large Lumbar Hernia Repairs

M. Calvin Cantrell, MD; Brian Dalton, MD; Ziad Awad, MD; Ruchir Puri, MD; University of Florida Jacksonville.

This video highlights two robotic-assisted lumbar hernia repairs with mesh. The first case is an initial presentation after trauma and the second case is a recurrent lumbar hernia after open hernia repair eight months prior. Both of these patients underwent chemo-denervation with botulinum toxin of the abdominal wall musculature to facilitate primary approximation. Video contains technical expertise while navigating challenging dissections and illustrates two successful repairs of lumbar hernias with a short length of stay, no complications and minimal morbidity.
Surgical Endoscopy (2021) 35:S350–S405

V127

Robotic-Assisted Laparoscopic Resection of a Posterior Wall GIST Near the Gastroesophageal Junction
Nathaniel Reed, DO; Fazaldin Moghul, DO; Abubaker Ali, MD; DMC Sinai-Grace Hospital.

Gastrointestinal stromal tumors (GISTS) require surgical intervention to prevent malignant transformation. However, GISTS occur in a variety of locations that present technical challenges intraoperatively. We present the case of a 51-year old male who was incidentally found to have a 2 cm GIST along the posterior wall of the stomach near the GE junction. This is typically the most difficult location to resect GISTS. We demonstrate our technique for a minimally invasive robotic-assisted laparoscopic approach with simultaneous EGD to perform the resection through an anterior gastrotomy. The patient recovered well and was able to be discharged home on POD#1.

V129

Laparoscopic Repair of Distal Esophageal Perforation
Joseph M Obeid, MD; Benjamin J Flink, MD, MPH; Zaina Naeem, MD, MPH; Salvatore Jr. Docimo, DO; Aurora D Pryor, MD; Stony Brook Medicine.

Esophageal perforation is traditionally treated by a thoracic approach, we present the case of a distal esophageal perforation treated laparoscopically. Major steps of this procedure include hiatal exposure, identification of the esophageal perforation, endoscopy, repair of defect with reinforcement, jejunal feeding tube placement, and drainage. Endoscopic examination of the esophageal perforation allows for evaluation of mucosal involvement and possible repair. Laparoscopic distal esophageal perforation repair can be safely performed by an experienced laparoscopic surgeon. This minimally invasive approach includes therapeutic benefits of thoracic approach and may decrease post-operative pain and recovery time.

V128

Robotic Removal of Chronically Slipped Adjustable Gastric Band and Conversion to Roux-en-Y Gastric Bypass
Maryna Chumakova-Orin, MD; Estefany Garces; Eddy Lincango, MD; Alfredo D Guerron; Duke Medical Center.

56 year old woman with history of morbid obesity for which she underwent remote adjustable gastric band (AGB) that was complicated by slippage requiring revision. The band, however, slipped again causing severe reflux. Thus she was offered robotic removal and Roux-en-Y gastric bypass (RYGB). The case was performed robotically and was started by careful dissection around the gastric band ensuring that no gastrotomies were created and the capsule was removed. Our RYGB was performed in the same setting with stapled gastrojejunostomy with common channel oversewn, and stapled jejunojejunostomy with common channel oversewn. Mesenteric defect and Petersens space were also closed.

V130

Robotic-Assisted Duodenal Web Resection in a 48-year-old Woman
Elaine M Griffeth, MD; Christopher Moir, MD; Juliane Bingener, MD; Mayo Clinic.

This video describes a robotic-assisted re-operative repair of a congenital duodenal anomaly after an unspecified operation as a neonate. Growth and development were normal; however, during adulthood she experienced progressive duodenal obstruction managed by serial dilation. On presentation to our center, she was tolerating liquid diet only and had lost weight. At re-operation, a non-patent diverting loop duodenojejunostomy was identified. With endoscopic assistance using the robotic “picture-in-picture” function, the duodenal web and windsock deformity were identified and excised through a longitudinal duodenotomy. Repair was completed with a transverse duodenoplasty. The patient did well and is now tolerating a regular diet.
Laparoscopic Right Adrenalectomy for Large Adrenal Tumor.
Dhanashree Moghe, Dr; Abhay Dalvi, Dr; Seth G.S. Medical College and K.E.M Hospital.
This is a video of laparoscopic right adrenalectomy for a large right adrenal tumor of 11 cm in size. Port placement is as for a standard adrenalectomy with an additional assistant port in the right subcostal area. The video demonstrates the complete and careful dissection of the tumor all around and focuses on the subtle difficulties encountered during a laparoscopic adrenalectomy. It is usually believed that laparoscopic adrenalectomy is difficult for large adrenal tumors hence we share our experience of performing laparoscopic adrenalectomies even for large tumors, as in this case, 11 cm as laparoscopic surgery has numerous advantages over open.

Robotic-Assisted Mesh Explantation and Primary Hernia Repair
Jessica A Cutler, MD; Tejinder P Singh, MD; Albany Medical Center.
Mesh infection is a feared complication of ventral hernia repair. Traditional open mesh explantation imposes significant morbidity on the patient, with large incisions and potential difficulty with abdominal wall coverage. Dense adhesions and erosions between the mesh and bowel can also complicate removal. We present a case of minimally invasive mesh explantation and primary hernia repair performed with a robotic approach, enabling multiple arms for retraction, a three dimensional magnified view of the bowel-mesh interface, and minimal incisional burden to the patient.

Secondary Achalasia Post Adjustable Gastric Band Requiring Delayed Resection of Pseudocapsule
Ekaterina Kouzmina, MD; Robert Bechara, MD; Boris Zevin, MD, PhD; Kingston Health Sciences Center.
This video is a case presentation of a patient with secondary achalasia and obstructive symptoms post removal of adjustable gastric band. The obstruction was caused by intact pseudocapsule requiring surgical resection and placement of a feeding gastrostomy tube. We present pre-op endoscopic and esophageal manometry images and intra-operative findings on laparoscopy and gastroscopy. Resection of the pseudocapsule resulted in symptom resolution. Upon reviewing literature we present a summary of three similar case reports. We recommend resecting the anterior component of the pseudocapsule during adjustable gastric band removal in patients with known esophageal dysmotility and dilation of esophagus on UGI series.

Management of a Complication During Laparoscopic Sleeve Gastrectomy
Chetna Bakshi, MD; Jenny Choi, MD; Diego Camacho, MD; Montefiore Medical Center.
This is a video presentation of a sleeve gastrectomy complicated by stapling over an orogastric tube near the angle of His. The video demonstrates our management of this intraoperative complication. After resecting the staple line, the orogastric tube was able to be removed. We then did a primary handsewn repair in two layers. A leak test was done to ensure an airtight repair, which was negative. Post-operative day 1 the patient underwent an upper GI study which demonstrated no contrast extravasation. He was started on a bariatric stage 1 diet and was discharged the following day.
V136

Laparoscopic Excision of Urachal Cyst and Remnant

Zaina Naeem, MD, MPH; Joseph M Obeid, MD; Amy L Rosenbluth, MD; Aurora D Pryor, MD, MBA; Kinga Powers, MD, PhD; Stony Brook Medicine.

The urachus serves as an embryonic communication between the allantois and the cloaca, and normally degenerates following birth. Defects in obliteration can lead to urachal abnormalities, which may manifest as cysts, sinuses, or diverticula. Urachal defects are a rare congenital anomaly, with an incidence of approximately 1:5,000 in adults compared to 1:150,000 in pediatric patients. Few adult cases of infected urachal remnants have been reported in the literature. Here, we describe urachal cyst/remnant infection in an adult male and uniquely leverage a video platform to highlight steps of a laparoscopic approach to excision.

V138

Video Presentation of Laparoscopic Repair of Recurrent Hiatal Hernia After Gastric Bypass Using Ligamentum Teres Cardiopexy

Dustin S Powell, MD; John J Kelly, MD; UMass Memorial Medical Center.

A 45 year old woman was referred to us with a remote history of a laparoscopic gastric bypass, and recent laparoscopic hiatal hernia repair 6 months prior. She endorsed severe dysphagia to solid food and chest pain. She was found to have a recurrent hiatal hernia on preoperative imaging. We managed this surgically with a laparoscopic redo hiatal hernia repair with mesh and ligamentum teres cardiopexy as detailed in this video. This was a challenging operation due to the multiple prior foregut operations. The patient had an excellent outcome with resolution of her dysphagia and chest pain.

V139

Robotic Morgagni hernia repair in an elderly woman

Maria E Linnaus, MD; Paul L Linsky, MD; Rana M Higgins, MD; Medical College of Wisconsin.

Morgagni hernia is a rare congenital diaphragmatic hernia. It can present with symptoms of obstruction or chest pain and shortness of breath. Surgical repair is often indicated when diagnosed. We present a case of a 73-year-old female who underwent robotic Morgagni hernia repair with mesh. The fascial edges were exposed and the defect closed primarily with braided nonabsorbable suture with pledges in horizontal mattress fashion. A 10 × 15 cm composite macroporous PTFE mesh was used to reinforce the closure. The patient did well postoperatively and her preoperative symptoms resolved. The robotic platform can be a useful adjunct in repair of Morgagni hernias.

Laparoscopic Drainage of Mesenteric Abscess from a Foreign Body Material (Suture)

JaeHee Yoon, MD; Shan Sivanushanthan; Dany Barrak, MD; Ivanesa Pardo, MD; 1MedStar Georgetown University Hospital; 2Georgetown University School of Medicine; 3MedStar Washington Hospital Center.

47-year-old lady with morbid obesity, who underwent roux-en-y gastric bypass surgery in 2012, presented with left-sided abdominal pain, nausea, and vomiting in October 2019. CT scan showed a complex and cystic mass, resembling a phlegmon, on the mesentery adjacent to the jejunal-jejunoanostomy anastomosis. It was successfully treated with antibiotics. She returned a year later with the same presentation and recurrence on imaging. Diagnostic laparoscopy revealed the mass to be an abscess cavity with retained foreign body, i.e. suture. After surgical drainage, drain placement, and antibiotic treatment, a follow-up scan showed complete resolution of the mesenteric abscess.
**V140**

**Intracorporeal Anastomosis for Colon Cancer; Evaluation of Blood Flow By Real-Time Fluorescence Visualization.**

Junichi Mazaki; Tetsuo Ishizaki; Tomoya Tago; Kenta Kasahara; Hiroshi Kuwabara; Masanobu Enomoto; Yuichi Nagakawa; Kenji Katsumata; Akihiko Tsuchida; Tokyo Medical University.

To reduce complications of intracorporeal anastomosis (IA), the usefulness of fluorescence visualization (FV) for evaluating blood flow during colorectal surgery has been reported. The SPY® Overlay mode of the 1688 AIM 4 K camera (Stryker® Corporation, Kalamazoo, MI) has a function that enables FV of near-infrared light to be superimposed on images of normal light, enabling real-time evaluation of blood flow, which cannot be evaluated in real time using conventional cameras. We introduced a new method of IA in which blood flow is evaluated in real-time using SPY® mode. This method was found to be effective in securing blood flow.

**V141**

**Laparoscopic completion cholecystectomy with indocyanine green in a rural hospital.**

Cesar O Reategui Sanchez, MD, FACS; Derek Grubbs, MS, IV; Missouri Delta Medical Center; New York Tech College of Osteopathic Medicine at Arkansas State University.

This is a 31-year-old obese female patient with a BMI of 46 kg/m2 who underwent elective robotic cholecystectomy for symptomatic cholelithiasis at an outside institution; subsequently she presented to us 7 months after with similar symptoms. Workup demonstrated a 3 cm gallbladder remnant. The operative report did not describe a subtotal cholecystectomy but a complete uneventful robotic cholecystectomy. The patient underwent an uneventful outpatient laparoscopic completion cholecystectomy with fluorescent and fluoroscopic cholangiogram; fluorescent cholangiogram allowed for clear visualization of the common bile duct at all times. Pathology showed chronic cholecystitis and 2 gallstones in the gallbladder remnant.

**V142**

**Phytobezoar After Sleeve Gastrectomy In a Patient with Duodenal Diverticulum**

Yen-Yi Juo, MD, MPH; Jin Yoo, MD; Duke University.

The patient was a 68-year-old female who had a laparoscopic sleeve gastrectomy about 5 months ago. She presented with 2 days of nausea, vomit and abdominal distension to the emergency department. Computed tomography demonstrated small bowel obstruction with a transition point involving a bezoar. In addition, a large diverticulum arising from the distal duodenum was found. During diagnostic laparoscopy, a small enterotomy was made just proximal to the bezoar and the bezoar milked out. Subsequently, the distal duodenum was mobilized and the diverticulum was amputated.

**V143**

**A Reinforced Biologic Augmented Repair (ReBAR) of Inguinal and Incisional Hernias with Robotic Assistance**

Cory J Banaschak, DO; Paul Szotek, MD; Ascension St. Vincent Hospital; Indiana Hernia Center.

This video demonstrates a reinforced biologic augmented repair (or ReBAR) of both an inguinal hernia and incisional hernia with robotic assistance. The technique uses a hybrid of the TAPP repair for the left inguinal hernia as well as the single incision retrorectus repair for the midline incisional hernia. Aside from the unique combination of minimally invasive techniques, the video also demonstrates handling of a reinforced bioscaffold mesh in laparoscopic and robotic applications. The "anatomic cut" of the mesh was developed over many cases to allow for efficient and effective placement into the myopectineal orifice during inguinal hernia repair.
**Robotic Assisted Abdominoperineal Resection with Extended Total Mesorectal Excision – A video vignette**

Sanket Bankar, MCh; Vivek Sukumar, MCh; Swapnil Patel, MCh; Tushar Pawar 2 Pawar, MCh; Jitender Rohila, MCh; Ashwin Desouza, MCh; Avanan Saklani, MS, FRCS; Tata Memorial Centre, Mumbai.

**Aim:** To demonstrate feasibility of robotic abdominoperineal resection with extended total mesorectal excision.

**Material & Methods:** A 37-year-old gentleman with large cell neuroendocrine carcinoma received radiation of 50 Gy and concurrent 5 cycles of cisplatin and etoposide. He underwent robotic assisted abdominoperineal resection – extended TME approach.

**Results:** Total operative time was 400 min. Postoperative course was uneventful and patient was discharged on the 5th post operative day.

**Conclusions:** Although Total mesorectal excision is the gold standard for rectal cancers, it may be essential to go beyond the mesorectal plane in certain unique situations such as the one demonstrated in this video.

**Transgastric Laparoendoscopic R0 Resection of Large Gastrointestinal Stromal Tumor near the Gastroesophageal Junction**

Bethany Briggs, DO; Jeffrey J Kraft, MD; Toghrul Talishinskiy, MD, FASMBS, FACS; 1Bayonne Medical Center, CarePoint Health; 2Advance Laparoscopic Associates; 3St Joseph’s Regional Medical Center.

Patient is a 51-year-old-male with epigastric pain. Abdominal ultrasound showed a heterogeneously hypoechoic structure between the left hepatic lobe and pancreatic body. EGD showed a 7.5 cm lesser curvature gastric mass, 1 cm from the gastroesophageal junction. Biopsy was positive for GIST. After oncologic evaluation, patient underwent laparoendoscopic transgastric resection. Under endoscopic visualization, two 10 mm trochars and one 5 mm trochar were inserted into the greater curvature. Laparoscopic endoscope was introduced and the mass was resected transluminally with an endostapler. The mass was found to have negative margins on frozen section. The gastric enterotomies were repaired with endostapler. Final pathology margins were negative.

**Robotic Duodenojejunostomy for SMA Syndrome**

Sullivan A Ayuso, MD; Michael H Genz, MD; B T Heniford, MD; Vedra A Augenstein, MD; Carolinas Medical Center.

A 29-year-old female with prior history of ileoectomy for ileocolic intussusception presented to clinic with chronic abdominal pain, cyclical emesis, and diarrhea. She had an extensive workup, which included CT enterography that revealed a narrowed angle of SMA takeoff. A diagnosis of SMA syndrome was made. The decision was made to proceed to the operating room where a robotic duodenojejunostomy was performed. There was no leak seen on leak test after the construction of the anastomosis. The patient noted resolution of symptoms during her postoperative clinic visit.

**Laparoscopic Revisional Gastric Bypass After Sleeve Gastrectomy Leak**

Thomas Q Xu, MD; Marc Sarran, MD; John Lewandowski, MD; Benjamin Veenstra, MD; Scott Schimpke, MD; Rush University Medical Center.

We present a case report of a patient who developed a gastropleural fistula from a staple line leak occurring three months postoperatively that was successfully managed with conversion to a Roux-en-Y esophagojejunostomy. Veres entry was used to gain access to the abdomen and was replaced with a 12 mm trocar. A 12 mm trocar was placed periumbilically. 5 mm and 12 mm trocars were placed below the right costal margin and hemi abdomen, respectively. A Roux-en-Y retrocolic esophagojejunostomy was performed. Intraoperative upper endoscopy did not demonstrate a leak. An upper GI fluoroscopy five days post-procedure did not demonstrate active extravasation.
V150

Single-port intragastric wedge resection using the “tunnel” method

So Hyun Kang; Sang Jun Lee; Yongjoon Won; Young Suk Park; Sang-Hoon Ahn; Yun-Suhk Suh; Hyung-Ho Kim; Seoul National University Bundang Hospital.

Gastric wedge resection is performed to treat gastric submucosal tumors (SMTs), and intragastric wedge resection is especially useful for SMTs that are mostly endophytic. However, the procedure is a difficult to perform for some patients whose stomach is far from the umbilicus, where the stomach is often pulled out to create the intragastric opening. The tunnel method using another wound retractor was developed to overcome this hurdle. This video shows how single-port intragastric wedge resection using the tunnel method is performed for a female 38-year old patient presenting with a gastric SMT in the cardia.

V152

Robotic Total Mesorectal Excision using a Modular Robotic System

Jeremy R Huddy, MR; Ahmed S Nizar, MR; Henry S Tilney, MR; Frimley Health NHS Foundation Trust.

This video demonstrates a robotic total mesorectal excision (TME) using a novel modular robotic system. The patient was a 40-year-old female patient with a rectal cancer at 10 cm from the anal verge. Three bedside units were on the patients right for the visualization arm and two instrument arms. A further bedside unit was on the left for another instrument arm. Medial to lateral mobilization of the sigmoid colon was undertaken and a TME dissection to pelvic floor. The patient made a good post-operative recovery and was discharged home on day 5. Histology confirmed pT2N1 adenocarcinoma with R0 resection.

V151

A case of ileal pouch volvulus: salvage by laparoscopic detorsion

Jennifer L Miller-Ocuin, MD; Jean H Ashburn, MD; Wake Forest School of Medicine.

In patients requiring complete removal of the diseased colon and rectum, restorative proctocolectomy with ileal pouch anal anastomosis provides improvement in patient quality of life measures. Ileal pouch complications most commonly include pouchitis or bowel obstruction. Pouch volvulus is a rare complication with ill-defined management owing to a paucity of literature, limited to case reports and small case series. This rare occurrence requires early recognition and intervention. In this video, we present a young woman with ileal pouch volvulus, a rare complication of restorative proctocolectomy. This video case presentation highlights the feasibility of successful salvage by laparoscopic detorsion.

V153

Laparoscopic conversion from Single Anastomosis Duodeno-Jejunal Bypass with Sleeve gastrectomy (SADJ-S) to Roux-En-Y Gastric Bypass (GBP).

Meritxell Pera Ferreruela, Resident; Ramon Vilallonga, MD, PhD; Amador Garcia Ruiz de Gordejuela; Marc Beisani; Elsa Garcia Möller, Resident; Enric Caubet, MD, PhD; Oscar Gonzalez, MD, PhD; Jose Manuel Fort; Manel Armengol; General surgery Department. Vall d’Hebron University Hospital, Universitat Autònoma de Barcelona.; Endocrine, Metabolic and Bariatric Unit, Vall d’Hebron University Hospital, Universitat Autònoma de Barcelona. Center of Excellence for the EAC-BC.

SADI-SG (Single Anastomosis Duodeno-ileal gastric Bypass with Sleeve gastrectomy (SADJ-S) is an accepted option for patients to treat obesity. However, this procedure can encounter difficulties in the follow-up. We herein, present a 57-year-old female who had a SG due to BMI 52.35 kg/m2 and a planned second stage SADI-S, suffered from severe malnutrition and required conversion to proximal SADI-S (45 cm from the angle of Treitz). Weight regain appeared and the decision was made to convert the patient to a Gastric bypass. We aim to show the technical aspects related to the duodeno-antral resection, intraoperative management, pitfalls, and technical issues during that procedure.
Laparoscopic revision of Nissen to Toupet fundoplication

Cyril Kamya, MD; Amos Zimmerman, MD; Edward Auyang, MD; University of New Mexico school of Medicine.

We report a case of a 21-year-old male who presented with adult-onset dysphagia after previous Nissen fundoplication initially created at age 10.5 months. The patient then presented to our institution, at which time EGD showed evidence of tight Nissen fundoplication. Laparoscopic exploration revealed that the fundoplication was partially disrupted, herniated, and twisted causing a long-segment distal stricture. To alleviate the patient’s presenting symptom of dysphagia as well as prevent possible future reflux, it was decided to revise the Nissen into a partial fundoplication. This was successfully accomplished laparoscopically with subsequent resolution of the patient’s symptoms.

The Feasibility of Robotic Repair of an Incarcerated Femoral Hernia

Bianca Fischer1; Jarot Guerra, MD2; David Weithorn, MD3; George Mazpule, MD3; Adam Rosenstock, MD3; Stephen Pereira, MD3; 1St. George’s University School of Medicine; 2Rutgers New Jersey Medical School General Surgery Residency; 3Hackensack University Medical Center.

Under general anesthesia, the abdomen was insufflated. Three 8 mm trocars were used. There was evidence of incarcerated small bowel in the left femoral space and an incidental right femoral hernia. The peritoneal flap was created bilaterally. Incision of the lateral aspect of the muscle and fascia along the medial aspect of the hernia defect allowed reduction of the small bowel. Intestinal perfusion was assessed with intravenous ICG and deemed adequate. The sac was reduced, and the round ligament divided. Self-fixating mesh was placed in the preperitoneal space. The flap was closed with a barbed suture. Finally, a laparoscopic TAP block was performed.

NOTES for Esophageal Perforation

Paul S Chandler; Igor Brichkov, MD; Maimonides Medical Center.

Esophageal perforation has high morbidity and mortality. Iatrogenic is more common than spontaneous and early treatment has better outcomes than late. Traditionally these patients are managed with thoracotomy. We present 3 consecutive patients with esophageal perforations treated with Natural Orifice Transluminal Endoscopic Surgery (NOTES). Managing these patients with transesophageal mediastinoscopic and thoracoscopic washout, directed placement of mediastinal drain, and covering the perforation with a Fully Covered Self-Expanding Metal Stent is safe and effective. All patients had technical success and were discharged from the hospital.

Cushing Syndrome due to Adrenal Adenoma During Pregnancy: A Case Report and Review

Benjamin H Lieberman, DO1; Elliot J Scott, MD2; Rachel Meislin, MD2; Maria Skamagas, MD2; Maria Mella, MD2; Gustavo Fernandez-Ranvier, MD, PhD2; 1Brookdale Hospital Medical Center; 2Mount Sinai Health System.

Cushing syndrome (CS) in pregnancy is a rare occurrence with no therapeutic recommendations based on high quality control trials. Here we present a 28-year-old female during her first pregnancy who receives the rare diagnosis of CS during her second trimester, undergoes laparoscopic right adrenalectomy, and is discharged home. We review the changes in physiology, diagnosis, and treatment of CS as they relate to the pregnant patient. We believe the treatment regiment this patient received—early recognition and inpatient diagnosis, early interdisciplinary involvement, temporizing medical management with timely curative surgery—resulted in an optimal patient outcome.
V158

Laparoscopic Small Bowel Resection For Perforated Jejunal Diverticulitis

Yao Z Liu, MD; Sean Lee, BA; Marcoandrea Giorgi, MD; Brown University.

We present a case of a 63 year old male with localized perforated jejunal diverticulitis who failed 2 months of non-operative management, eventually requiring laparoscopic small bowel resection. Jejunal diverticulitis is rare and standards of care have not been well established. Non-operative management with intravenous antibiotics and bowel rest may be attempted first, but patients who fail to improve may require surgical intervention. We propose a laparoscopic approach as a safe, effective method to treat perforated jejunal diverticulitis.

V160

Endoscopic Extraction of Foreign Body and Management of Gastro-gastric Fistula

Rolfy Perez Holguin, MD; William Wong, DO; Justin Doble, MD; Vamsi Alli, MD; Penn State Health.

This video demonstrates the concomitant endoscopic management of weight recidivism in a patient following roux-en-Y gastric bypass with a gastrogastric fistula and removal of an ingested sewing needle resulting in a jejunal perforation. The case highlights the importance of evaluating retrieved foreign bodies for completeness. The length of the retrieved foreign body was discordant to its measured length on radiographic imaging, suggesting that a fragment remained in the gastrointestinal tract. Closure of the GG fistula was achieved in the standard fashion by first ablating the epithelial tract with an argon plasma coagulation catheter, followed by closure using an over-the-scope clip.

V159

4K Laparoscopic proximal duodenectomy

Filipe Kunzler1; Abdelrahman M Attili; Neha Lad2; Ramon E Jimenez3; Horacio J Asbun1; 1Miami Cancer Institute; 2Case Western Reserve University School of Medicine.

This video shows a laparoscopic duodenectomy, performed with a curative intent for an incidentally found neuroendocrine tumor. The patient is a 47 year-old and had the tumor found while he was working-up abdominal pain. Dissection starts dropping the hepatic flexure of the colon and then moves towards the duodenum. The duodenum is progressively freed from the pancreas, proximally to the ampulla. The patient was discharged on postoperative day 2 without complications.

V161

Laparoscopic Clipping of Left Gastric Artery Aneurysm

Roberto Cortez, MD; Marcoandrea Giorgi, MD; Brown University Department of Surgery.

A 72-year-old male presented to the emergency department with acute onset abdominal pain. CT cross-sectional imaging revealed multiple aneurysms of the large vessels to include the splenic artery and the left gastric artery with a contained retroperitoneal hematoma. VIR was able to coil embolize the splenic artery effectively, however due to the tortuous nature of the left gastric artery they were unable to access the vessel making surgical intervention indicated. The attached video captures the salient details of the operation, where we performed a laparoscopic clipping of the left gastric artery aneurysm.
Robotic Partial Splenectomy for Upper Pole Splenic Lesion
Victoria J Grille, MD; Victoriya Staab, MD; Seth Kipnis, MD; Jersey Shore University Medical Center.
In this video, the authors demonstrate a robotic partial splenectomy in a 13 year old male, who was incidentally found to have an upper pole splenic lesion on CT scan. Differential diagnoses included a hemangioma, hamartoma, SANT (sclerosing angiomatoid nodular transformation) lesion, as well as an angiosarcoma. Due to the possibility of a malignancy, a multidisciplinary decision was made to resect the lesion in a combined procedure with the Pediatric and Robotics surgery teams. The patient received preoperative vaccinations in the event that a formal splenectomy was required, however, ultimately underwent a successful partial resection with pathology showing a hemangioma.

Vis-à-Vis Sleeve Gastrectomy: a Video Case Report
Athar Elward, MD; Cairo University.
Laparoscopic sleeve gastrectomy (LSG) technical shortcomings incur its most serious complications like leakage and reflux. Vis-à-vis sleeve gastrectomy (VVSG), as the expression suggests, is simply an obverse sleeve gastrectomy based on the greater curve. The VVSG technique is specifically designed to address LSG technical shortcomings while maintaining its basic concept and advantages. Given the multiple anatomical and functional expected advantages of this technique, future comparative studies are needed to verify these prospects. This is a video case report of the first case of laparoscopic VVSG in a morbidly obese patient along with the first year results.

Laparoscopic Transgastric Resection of a GIST
Emily J Watters, MD, MPH, Erin Moran-Atkins, MD; Montefiore Medical Center.
This is a case presentation of a gastrointestinal stromal tumor (GIST) located on the lesser curvature of the stomach. In this video, a laparoscopic transgastric resection of a GIST is performed through a gastrotomy on the greater curvature of the stomach. In this way, the tumor was able to be everted to allow for transection at its base without requiring a larger gastric resection and reconstruction.

Laparoscopic Splenectomy after Partial Splenic Embolization
Emily J Onufer, MD, MPH; William Sherrill III, MD; L. Michael Brunt, MD; Washington University in St. Louis.
We present a case of a 73 year old female with idiopathic thrombocytopenic purpura refractory to multiple medical treatments and a platelet count of 1000. She had undergone prior embolization of her superior splenic artery branch embolization with interventional radiology one month prior to referral with subsequent CT scan showing at least 75% embolic coverage. This video depicts a laparoscopic splenectomy and splenule removal in the setting of splenic infarction and extensive adhesions. In a step-by-step fashion, splenic attachments were transected until only the hilum remained. This was divided using a vascular stapled. An accessory spleen was also removed.
V166

Robotic revision of ureteral stricture in a transplant kidney with Boari flap
Daisuke Imai; Yuzuru Sambommatsu; Aamir Khan; Seung Duk Lee; Amit Sharma; David Bruno; Vinay Kumaran; Adrian Cotterell; Marlon Levy; Chandra Bhati; Virginia Commonwealth University.

A 67-year-old African-American male with history of end stage renal disease state post kidney transplant presented with hematuria and abdominal discomfort 29 month after the kidney transplant. Workup revealed a ureteral stricture causing hydronephrosis in the renal allograft. He was initially treated with nephroureteral stents that were later converted to a percutaneous nephrostomy tube (PCN) plus double-J stent. Multiple PCN exchanges and stent removal did not improve his symptoms. Robotic surgery using the da Vinci Xi® system was used to create a Boari flap ureteroneocystostomy, which reestablished ureteral patency and relieved his symptoms.

V168

Robotic Approach to Metastatic Rectal Gastrointestinal Stromal Tumor
Michael Caparelli, MD; Brianne Runyan, MD; Cory Barrat, MD; Shyam Allamaneni, MD; Jewish Hospital of Cincinnati.

We report a case of rectal gastrointestinal stromal tumor metastatic to the liver treated by robotic approach. The patient is a 50-year-old male otherwise healthy who was referred to colorectal surgery for rectal bleeding. Colonoscopy revealed a 7 cm mass 10-12 cm from the anal verge. Biopsy was consistent with GIST. Staging revealed multiple hepatic metastases. He underwent robotic partial left hepatectomy and low anterior resection. The patient was discharged on post op day four without any postoperative complications. He received imatinib mesylate for six months and returned to the OR for robotic resection of the rightsided metastatic lesions.

V167

Gastric Bypass with History of Gastric Neurostimulator for Gastroparesis and Obesity
Christopher Manieri, DO; Rajev Nain, MD; Inova Hospital System.

Laparoscopic gastric bypass can be a useful surgical option for patients with gastroparesis and morbid obesity. These patients can also have gastric neurostimulators or feeding tubes placed in severe cases. This video highlights the challenges of performing a gastric bypass in a patient with a history of an open jejunostomy tube as well as a gastric neurostimulator.

V169

Strategy and Technical Considerations for Laparoscopic Choledochoduodenostomy
John Yonge, MD; John K Saunders, MD; Akuezunkpa Ude-Welcome, MD; New York University.

A 77 year old West African female presented to the Emergency Department with recurrent right upper quadrant pain. The patient was found to have symptomatic choledocholithiasis. Two decades prior she underwent an open cholecystectomy and over the past three years, she received three ERCPs including sphincterotomy for symptomatic choledocholithiasis without resolution of her symptoms. Her workup did not reveal any parasitic, infectious or structural causes for her recurrent stone formation. In the video we describe our technique for completing a laparoscopic choledochoduodenostomy with intraoperative choledoscopy for complete evaluation of the entire extrahepatic biliary tree.
V170

Indocyanine green near-infrared fluorescence imaging guided surgery in laparoscopic complete mesocolic excision for splenic flexure cancer with accessory middle colic artery

Hidekazu Takahashi, MD, PhD; Tsuyoshi Hata, MD, PhD; Takayuki Ogino, MD, PhD; Norikatsu Miyoshi, MD, PhD; Mamoru Uemura, MD, PhD; Hirofumi Yamamoto, MD, PhD; Tsuchikazu Mizushima, MD, PhD; Yuichiro Doki, MD, PhD; Hidetoshi Eguchi, MD, PhD; Department of Gastroenterological Surgery, Osaka University Graduate School of Medicine.

Surgery for colorectal cancer located in the splenic flexure is difficult to perform because of the complex anatomy. In addition to the middle colic artery (MCA) and left colic artery (LCA), the accessory middle colic artery (AMCA) has been recognized as a feeding artery for the left-sided colon. To address this issue, using indocyanine green (ICG) near-infrared fluorescence imaging may helpful for understanding anatomy, intraoperatively. Here we show the movie on an around 40-year-old female with advanced transverse colon cancer at the “splenic flexure”.

V171

Robot-Assisted Pancreaticoduodenectomy

Caitlin Takahashi-Pipkin1; Kenneth Meredith2; 1Brody School of Medicine at East Carolina University; 2Sarasota Memorial Hospital.

We are presenting a case of robot-assisted pancreaticoduodenectomy in a patient with a replaced right hepatic artery. The technique involves performing complete dissections and isolating the common bile duct, stomach, and pancreatic neck at the location of planned division. The replaced right hepatic artery is visualized during dissection and the gastroduodenal artery is safely dissected. The margins are transected, and the cholecystectomy is performed followed by reconstruction with a stapled isoperistaltic antecolic Billroth II. The pathology report demonstrates a 2.2 cm tumor, with 0 of 26 lymph nodes positive and an R0 resection.

V172

Lateral Pelvic Node Dissection with the Preservation of Nerves & Arterial Branches in the Advanced Mid/Low Rectal Cancer or Suspected Lateral Pelvic Node

Jeehye Lee, MD; Sung-Bum Kang, MD, PhD; Department of Surgery, Seoul National University College of Medicine, Seoul National University Bundang Hospital, Seongnam, Korea.

Lateral pelvic lymph node dissection (LPND) in low rectal cancer was first described in the 1950s to reduce local recurrence. Still there is no formal consensus or mutually agreed guidelines for LPND. As the first step for definitive conclusion of LPND, the standardization of surgical techniques is needed. We propose the stepwise en-bloc LPND including the lateral wall dissection, the medial wall dissection, the central area dissection along the branches of internal iliac artery, and the distal/dorsal wall dissection with the preservation of nerves and arterial branches in cases of advanced mid/low rectal cancer, or suspected lateral pelvic node.

V173

Robot Assisted LINX Device Removal, Re-do Hiatal Hernia Repair with Mesh, and Anterior Fundoplication

Doris Kim, MD; Shushmita Ahmed, MD; Hazem Shamseddien, MD; UC Davis.

The LINX device has become an increasingly popular procedure for patients with GERD. However, its removal is reported at 5.5–9.2%. The most common reasons for removal are refractory dysphagia, recurrent/persistent GERD, and erosion. We present a case of robotic LINX removal, redo hiatal hernia repair and anterior fundoplication. The patient underwent laparoscopic hiatal hernia repair with Linx device insertion and presented 4 years later with a recurrent hiatal hernia, migrated device, and symptoms of cough, dysphagia and reflux. This case highlights the operative challenges of LINX removal, and how a robotic approach allows for superior visualization and safe device removal.
**V174**

LAPAROSCOPIC COMPLETE MESOCOLIC EXCISION FOR RIGHT COLON CANCER

Luigi Boni, MD, FACS; Ludovica Baldari, MD; Massimiliano Della Porta, MD; Elisa Cassinotti, MD, PhD; Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico di Milano.

This video shows a laparoscopic right colectomy with complete mesocolic excision for cancer. After exposure of right and transverse mesocolon and identification of superior mesenteric vein, ileocolic vessels and right branches of middle colic vessels were isolated and divided. The dissection carried on with peripancreatic dissection at the level of Henle’s trunk with division of right colic vein and preservation of gastroepiploic vein. After division of gastro-colic ligament and dissection of Toldt fascia, transverse colon and terminal ileum were divided with linear stapler. Lateral mobilization of the colon was completed. A side to side ileo-colic intracorporeal mechanical anastomosis was performed.

**V175**

Endoscopic Management of Gastric Pouch Septum in Patient After Gastric Bypass

Alexander T Liu, MD; Colin G Delong, MD; Eric M Pauli, MD; Joshua S Winder, MD; Penn State Milton S. Hershey Medical Center.

Septotomy is a well described technique for managing post sleeve gastrectomy leaks by allowing for drainage of the abscess or fluid cavity. In this video, we review the use of endoscopic septotomy for the management of a gastric pouch septum occurring as the result of a previous sleeve leak with a gastrocolic fistula that was converted to Roux-en-Y gastric bypass. The fistula had resolved with endoscopic closure, and the gastric pouch septum was successfully managed with the septotomy, a procedure usually reserved for sleeve leaks.

**V176**

Robotic transabdominal explantation of chronically infected sublay mesh following open abdominal wall reconstruction

Mark J Anderson, MD; Ryan M Juza, MD; Case Western Reserve University, University Hospitals Cleveland Medical Center.

Explantation of infected synthetic ventral herniorrhaphy mesh is a challenging undertaking that is most commonly undertaken via open laparotomy. This approach presents multiple challenges. Most notably, repeated disruption of the strength layers of the abdominal wall and the well-known complications that often accompany open revisional operations. We present a case of a 63-year-old female who had previously undergone multiple ventral herniorrhaphies including an open posterior component separation with sublay synthetic mesh placement. Her course was complicated by recurrent infections and failed attempts at mesh salvage. We demonstrate successful robotic transabdominal explantation of a chronically-infected sublay mesh.

**V177**

A challenging misleading case of gastric cancer perforation, managed laparoscopically

Elisa I Bottazzoli, MD; Cristiano Parisi, MD; Amal E Nahal, MD; Mario Guerrieri, MD; Giuliani Antonio, MD; Alice Frontali, MD; Nicola De Angelis, MD; Raffaele De Luca, MD; Francesco Di Marzo, MD; Mansoor A Khan, MD, Phd, FRCS, FEBS, FACS; Shameen Jannoo, MD, FRCS; Salomone Di Saverio, MD, FACS, FRCS of England; University of Insubria, Varese; Université delle Marche; San Carlo Hospital, Naples; ASST Fatebenefratelli Sacco Hospital, Milan; Université Paris-Est Créteil, Paris; Istituto Tumori “G. Paolo II”, I.R.C.C.S., Bari; Val Tiberina-San Sepolcro Hospital, USL Toscana Sud-Est; Imperial College of London; Royal College of Surgeons of England.

A 65-years-old man (unremarkable PMH), with sudden epigastric pain, diffusing to the whole abdomen, peritonitis. CT scan showed free fluid and free air from probable perforated peptic ulcer. Primary suture was performed, intraoperative biopsies were taken. Histology: poorly differentiated carcinoma. Staging and possible neoadjuvant was scheduled. However, after 20 days, the patient started vomiting; CECT showed complete gastric outlet obstruction due to locally advanced pyloric carcinoma. Therefor the patient underwent laparoscopic subtotal gastrectomy, lymphadenectomy and intracorporeal gastro-jejunal anastomosis (B2). Histology: G3 gastric carcinoma pT4, pN3b (19/26), lymphovascular and perineural invasion. Adjuvant chemotherapy was performed. 6-months-follow up showed vertebral lumbar metastasis.
Left Upper Quadrant Only Approach to Laparoscopic Sleeve Gastrectomy Due to a Loss of Domain Ventral Hernia

Chase J Wehrle; Amel Komic, MD; Andrew Harner, MD; Renee L Hilton, MD; Aaron Bolduc, MD; Medical College of Georgia.

Bariatric surgery in a patient with obesity and a loss-of-domain hernia is essential to eventual hernia repair. We present a 59yo female with a BMI of 45, an extensive surgical history, and a 20x25 cm ventral hernia that precluded standard approach to the sleeve gastrectomy. Therefore, a laparoscopic vertical sleeve gastrectomy was performed through four ports placed in the left upper quadrant abdominal wall lateral to the hernia sac. The patient is losing weight now as planned. We present a novel approach to the laparoscopic sleeve gastrectomy that is useful in patients with loss-of-domain ventral hernias that preclude standard operative approach.

Intraluminal Indocyanine Green to identify jejunojejunostomy issues

Catriona Swift, DO; J Steve Scott, MD; Nicole Fearing, MD; Menorah Medical Center.

Vague abdominal pain, nausea, and vomiting are relatively common complaints after gastric bypass surgery. This can be caused by numerous different conditions which can be difficult to delineate on imaging. One such condition is reflux of enteric contents up the bilipancreatic limb. Due to diagnostic difficulties, these patients often end up with a diagnostic laparoscopy. We have developed a test using Indocyanine green intraluminally to test for problems with the jejunoojejunalostomy intraoperatively. This video features both a negative and positive result of this test, ultimately steering the operation in the correct direction to alleviate the patient’s symptoms.

Robotic Epiphrenic Diverticulum Resection, Myotomy, Collis Gastroplasty and Repair of Paraesophageal Hernia in Previous RYGB Patient.

Maher El Chaar, MD, FACS; Alvaro Galvez; Keith King, MD; St Luke’s University Health Network.

We present the case of a 56 year old female presenting with obstructive symptoms compatible with food impaction and preoperative imaging suggesting of gastric pouch herniation. Intraoperatively a large epiphrenic diverticulum was encountered and repaired along with the creation of a long cardiomiyotomy.

LAPAROSCOPIC HEMIDIAPHRAGM PLICATION, HIAITAL HERNIA REPAIR, MAGNETIC SPHINCTER AUGMENTATION AND GASTROPEXY

Robert Allman, MD; Austin Rogers, MD; James E Speicher, MD; Audrea Oliver, MD; Carlos J Anciano, MD; Mark D Iannentoni, MD; East Carolina University.

74 year old male who present with complaints of acid reflux and dysphagia. Upon evaluation the patient was found to have elevated bilateral hemidiaphragms and a sharp angulation of the gastroesophageal junction. The patient swallow study showed an outflow obstruction at the level of the GEJ secondary to the elevated left diaphragm. The patient was then taken to OR for a laparoscopic diaphragm plication, hiatal hernia repair, magnetic sphincter augmentation and fundic gastropexy. The patient did well postoperatively and was discharged on POD 2. Patient had resolution of his symptoms at his office follow up.
Robotic Repair of Grynfelt-Lesshaft Hernia – Tricks and Tips for Residents
Paula A Porras, MD; Patrick Kirkland, MD; Eric R Simms, MD, FACS; Harbor UCLA.

This video presents the case of a 42-year-old female with a 5-year history of worsening lumbar pain, who was found to have a fat-containing Grynfelt-Lesshaft hernia on CT scan. The patient elected for robotic surgical repair and intraoperatively was found to have two defects at the Grynfelt-Lesshaft distribution, which were successfully repaired with primary defect repair as well as mesh via a transabdominal pre-peritoneal (TAPP) approach with the Xi robotic system. The patient’s post-operative course has been uncomplicated and the patient endorses significant improvement in her pain since the surgery.

Laparoscopic Mesh Repair of Adult Bochdalek Hernia
Vivek Kaje, MBBS, MS, DNB, SS Surgical Gastroenterology; Ahris VF, MBBS, MS; Ananth K Prabhu, MBBS, MS; Harischandra B, MBBS, DNB, Surgery; Yenepoya Medical College, Deralakatte, Mangalore, Karnataka India 575,018.

Introduction: Bochdalek hernia in adults is extremely rare.
Presentation: 24-year-old male patient with abdominal and chest pain for 6 months duration presented to our unit. An absent left posterior hemidiaphragm and herniation of intra-abdominal organs like stomach, spleen, colon was noted in intravenous and oral whole abdominal CT.
Treatment: Patient was operated laparoscopically content as described in CT were pulled in to intraperitoneal area carefully. 20 × 15 cm intraabdominal mesh was fixed to the defect area with the help of sutures.
Conclusion: Adult Bochdalek hernia is very rare and when confronted laparoscopic treatment with mesh fixation can be performed safely.

Meso Esophagectomy for lower esophageal and junctional cancers – Radical Hiatal dissection.
Pradeep V Patil; Ganesh Radhakrishnan, FRCS; John Scollay, FRCS; Clements A Hollie, MRCS; Sami Shimi, MD, FRCS; Ninewells Hospital & Medical School.

This video of a man with a lower esophageal adenocarcinoma undergoing surgery after neoadjuvant chemotherapy demonstrates our operative strategy to maximise the chances of an R0 resection.
The steps as explained in the video run in an anticlockwise fashion.
1. Exposure of the hiatus
2. Superior hiatal dissection and skeletonization of the pericardium
3. En bloc resection of a cuff of the Right crus and Right pleura.
4. Aortic skeletonization and hiatal control of the thoracic duct
5. En bloc resection of a cuff of left crus with left pleura.
Pathology of the resected specimen was clear at all margins.

Removal of a Fobi Ring Causing Pseudoachalasia
Domenech Asbun, MD; Yilon Lima Cheng, MD; Enrique F Elli, MD, FACS; Mayo Clinic Florida.

We present the case of a patient who had undergone a Roux-en-Y gastric bypass with placement of a Fobi ring 16 years prior, developing significant dysphagia and pyrosis. Workup, including contrast esophagram, endoscopy, and manometry, revealed findings indicative of pseudoachalasia attributable to the Fobi ring. After identification and release of the Fobi ring, careful dissection is carried proximal to the gastroesophageal junction to assure no further strictures need releasing. After establishing a clearly patent LES, the diagnosis of pseudoachalasia is confirmed. Removal of the Fobi ring and release of constricting scar tissue resolved this patient’s symptoms.
Robotic Primary Repair of Bochdalek Hernia in an Adult Patient
Sarah Pivo, MD; Jacqueline Kim, MD; Paresh Shah, MD; Department of Surgery, NYU Langone Health.

We present the case of a newly-diagnosed incarcerated Bochdalek hernia with gastric outlet obstruction in a 28 year old female. She was noted on preoperative CT scan to have a 6.5 cm defect containing the entirety of her stomach and a collapsed loop of transverse colon. Preoperative endoscopy was performed to place nasogastric tube distal to the obstructed stomach, and the gastric mucosa appeared viable. However, gastric detorsion was unsuccessful. The hernia was then repaired via a robotic approach using a primary repair with a nonabsorbable 0 V-Loc suture. The patient remained asymptomatic post operatively.

Laparoscopic Takedown of Crohn’s Ileosigmoid fistula with Primary Sutured Repair
Chun Hin Angus Lee; Conor Delaney; Cleveland Clinic Foundation.

Approximately a third of patients with Crohn’s disease (CD) develop intra-abdominal fistula and up to 20% are ileosigmoid fistula (ISF). Although a laparoscopic approach is feasible in selective cases, it is associated with high rate of conversion to open. This video vignette illustrates some technical points in laparoscopic ISF takedown and repair in a patient with medical refractory CD complicated by a distal ileal stricture.

Robotic Transabdominal Preperitoneal (rTAPP) Spigelian Hernia Repair
Richard Lu; University of Texas Medical Branch.

This is a case presentation of a robotic transabdominal preperitoneal (rTAPP) Spigelian hernia repair. Our patient is a 67-year-old gentleman who presented to the emergency department with acute right lower quadrant abdominal pain. His workup demonstrated a right Spigelian hernia containing bladder and preperitoneal adipose tissue. He underwent an rTAPP repair with self-fixating mesh in an outpatient elective setting. This video highlights the key technical aspects of this procedure along with its pertinent anatomy.

Robotic Roux-en-Y Gastric Bypass after Failed Nissen Sleeve
Yilon Lima Cheng, MD; Domenech Asbun, MD; Enrique F Elli, MD; Mayo Clinic Florida.

We present the case of a patient with prior Nissen fundoplication and sleeve gastrectomy for reflux. Preoperative symptoms persisted, and she was referred to our institution for surgical revision. A contrast esophagram showed narrowing of the gastric body. The previous fundoplication was identified and taken down. The hiatus was reapproximated with interrupted sutures. A side-to-side stapled jejunoojejunostomy was performed. The gastric pouch was anastomosed to the roux limb using a two-layer hand-sewn anastomosis. The patient tolerated the procedure well, without post-operative complications, and was discharged on post-operative day four with resolution of preoperative symptoms.
V190

ROBOTIC EXTENDED DISTAL PANCREATECTOMY WITH SPLENECTOMY FOR PANCREATIC ADENOCARCINOMA

Sharona Ross, MD, FACS; Gabriel Rivera-Espineira, MD; Timothy Bourdeau, BS; Iswanto Sucandy, MD, FACS; Alexander Rosemurgy, MD, FACS; AdventHealth Tampa.

This video is of a robotic extended distal pancreatectomy with splenectomy undertaken in a 72-year-old lady who presented with epigastric abdominal pain. EUS/FNA demonstrated abutment of 180 degrees of SMV/SMA and encasement of splenic artery and vein. She progressed on 6 months of FOLFIRINOX and 30 sessions of radiation therapy. She received 3 months of gemcitabine and abraxane. The mass decreased in size with no evidence of abutment of SMA/SMV. She underwent an uneventful distal pancreatectomy with splenectomy. She tolerated the procedure well and was discharged on POD 4.

V191

Combined Robotic Total Colectomy and Hysterectomy for Medically Refractory Ulcerative Colitis (UC) and Uterine Fibroids with Transvaginal Specimen Extraction

Lance Horner, MD; Nadia Gomez, MD, MBA, FACOG; Ovunc Bardakcioglu, MD, FACS, FASCRS; University of Nevada Las Vegas School of Medicine, Department of Surgery; University of Nevada Las Vegas School of Medicine, Department of Obstetrics and Gynecology.

Natural Orifice Specimen Extraction (NOSE) in Colorectal surgery is a well-described procedure for both benign and malignant pathologies and is extracted via the anus/rectum or a colpotomy. Here we describe the case of a 39-year-old female with medically refractory ulcerative pancolitis to three biologics and concomitant large uterine fibroids. We demonstrate our technique for a combined robotic total colectomy and hysterectomy/bilateral salpingectomy, followed by specimen extraction through the vaginal cuff prior to closure. This shows the details of completing each of these operations as well as the technical aspects of extracting the total colectomy specimen through the vagina following hysterectomy.

V192

Robotic Combined Suture & Ventral Rectopexy (RSVR)

Adam Studniarek, MD; Cory Gall, MA; Luay Ailabouni, MD, FASCRS; Rutgers New Jersey Medical School; Pacific Northwest University of Health Sciences; Kadlec Regional Medical Center.

We present a case of a combined robotic suture and ventral rectopexy in a male with full thickness rectal prolapse. This method addresses both the hernia and the intussusception theory of rectal prolapse. We emphasize performing unilateral stalk dissection to avoid complete rectal denervation, circumferential dissection from mid to distal rectum and dissection of the redundant fat pad. The biological mesh is secured anterolaterally. The additional mid rectal sutures are placed to prevent intussusception of the mid rectum and to prevent lateral mesh migration. The unilateral suture rectopexy functions as a classic suture rectopexy and helps with tension free repair.

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Laparoscopic Management of a Transomental Internal Hernia

Michael Jureller, MD; Gina Kim, MD; Erin Moran-Atkin, MD; Montefiore Medical Center.

Small bowel obstruction in the patient without previous surgical history is an uncommon form of obstruction but must be treated expeditiously due to the risk of underlaying bowel compromise. We present a 45-year-old male who presented to our emergency room with a primary a small bowel obstruction. On exploration, he was found to have a transomental internal hernia with complete viability of the incarcerated small bowel. He was treated with reduction of the small bowel and division of the omental defect. His post operative course was uneventful.
Laparoscopic Sleeve Gastrectomy on a patient with Situs Inversus

Hamid Alipour, MD; David Thoman, MD; Santa Barbara Cottage Hospital.

Situs inversus occurs in 1 in 10,000 people and results in a mirroring of the internal organs. This can make laparoscopic surgery challenging with port set up and surgeon positioning. In this video, we present a 42-year-old woman with known situs inversus undergoing laparoscopic sleeve gastrectomy. The procedure was performed mirroring the original set up. Port locations remained identical, but the operating surgeon approached from patient left with the instruments in opposite hands.

Robotic Removal of a Devilish Angelchik Prosthesis

Michael R Keating, MD; Benjamin E Schneider, MD; University of Texas Southwestern.

The Angelchik prosthesis was an antireflux device which first came into use in 1979. It was comprised of a silicon ring that was placed around the gastroesophageal junction and secured with a Dacron tape. Its use was largely discontinued in the 1980s due to its association with numerous complications including migration, erosion, dysphagia, esophagogastric fistulas, etc. Though rarely seen today, ~30,000 of these devices were placed, and they can still be seen by practicing surgeons. This video documents, to our knowledge, the only robot-assisted removal of an Angelchik device in the literature.

Techniques for Endoscopic Management of Multiple Ingested Magnets

Colin G DeLong, MD; Anthony P Kronfli, MD; Alexander T Liu, MD; Christa N Grant, MD; Eric M Pauli, MD; Penn State Health.

Foreign body ingestions are a common problem managed by pediatric surgeons. Magnet ingestions, particularly with strong rare earth magnets and when multiple magnets or additional metallic foreign bodies are swallowed, can connect multiple loops of the gastrointestinal tract together and cause pressure necrosis, obstruction, and perforation. In this video case report, we describe the endoscopic evaluation and removal of multiple ingested magnets which had failed conventional removal methods. The video highlights the importance of multidisciplinary care and describes available techniques and tools for use in difficult cases.

Single Incision Radical Appendectomy for Appendiceal Mucocle (Sugarbaker-Moreno Technique)

Jorge L Gomez-Mayorga, MD; Natalia Cortes-Murqueitio, MD; Manuel Arrieta G, MD; Camilo Cetares, MD; Alejandro Rincon; Laura Gonzalez; Fernando Arias-Amezquits, MD, MBA, FISS, FSSO, FACS; Fundación Santa Fe de Bogotá.

Radical appendectomy was described by Sugarbaker-Moreno, in Surgical Oncology 2017, as an alternative of right hemicolectomy in patients with appendiceal neoplasms. We present the case of a 44-year-old female with a left adnexal mass and CT scan suggesting appendiceal neoplasm. Patient was taken to surgery and an appendiceal mass and a calcified myoma were identified; a single incision radical appendectomy and a myomectomy were performed. There were no complications registered during or after the procedure. The pathology showed a mucinous appendiceal neoplasm with negative margins without the need for additional oncological interventions.
Revisional Bariatric Surgery: Resleeve Gastrectomy
Laurie Fasola, MD, FRCSC; Kingston General Hospital.
Recently we were challenged with a failed sleeve gastrectomy with a significant abdominal wall defect which precluded us from converting the sleeve to a Roux en Y. However prior to offering a surgical procedure, patient was extensively investigated and literature was reviewed to guarantee best outcome. Finding of success with re-sleeve gastrectomy in selected cases encouraged us to offer this. Up to now patient has had great outcome. There is an algorithm proposed by Filip (2019) which summarizes the best management of a failed sleeve gastrectomy. This is available in the review. Re-sleeve Gastrectomy is successful in selected patients.

MINIMALLY INVASIVE LAR WITH COLOJEJUNAL FISTULA TAKEDOWN IN THE SETTING OF PRIOR EXPLORATORY LAPAROTOMY FOR COMPLICATED DIVERTICULITIS
Carla J Newton, MD; Rahila Essani, MD, FACS; Baylor Scott & White.
A 35 y.o. male originally required an open Hartmann’s procedure for complicated diverticulitis. We performed a robotic assisted LAR with colojejunal fistula takedown. The colostomy was taken down extracorporeally. Robotic ports were placed in the line from the RLQ to the LUQ. The colojejunal fistula was taken down and the splenic flexure, remaining sigmoid colon, and proximal rectum were mobilized. The rectum was transected below the anterior reflection. The fistulized jejunum was extracorporealized and resected with a stapled anastomosis. The colonic specimen was extracted via the prior colostomy site. Colorectal anastomosis was created with a 28 mm EEA stapler.

Robotic Repair of Herniated Gastric Sleeve with Revision to Roux-en-Y Gastric Bypass
Peter Einersen, MD; Gustavo Fernandez-Ranvier; Mount Sinai.
This video reviews robotic management of a complex bariatric revision. A 46 year-old woman with prior sleeve gastrectomy presented with chief complaints of weight regain to a BMI 45 and progressive dysphagia and GERD. Workup revealed that her gastric sleeve had herniated into the mediastinum. We proceeded to the operating room for a robotic-assisted repair of the large hiatal hernia and conversion of the sleeve to a roux-en-Y gastric bypass, with the highlights presented here. The patient has had excellent clinical response with complete resolution of symptoms and 15 pounds weight loss at 2 weeks from surgery.

Laparoscopic Left Hemi-hepatectomy for Intrahepatic Cholangiocarcinoma Abutting Peri-portal Vasculature
Omobolanle Oyefule, MD; Maria Fonseca, MD; Ana Pena, MD; Alejandro Cracco, MD; David Gutierrez-Blanco, MD; George Tadros, MD; Emanuele Lo Menzo, MD; Mayank Roy, MD; Conrad Simpfendorfer, MD; Mayo Clinic, Rochester; Cleveland Clinic Florida.
A 63-year-old female with a history of breast cancer presented with epigastric pain. MRI liver demonstrated a 3.8 cm T1 hypointense/T2 hyperintense mass in segment III. Biopsy was positive for adenocarcinoma. Preoperative imaging and lab testing were negative. Intraoperatively, the mass abutted the left portal vein. After peri-portal lymphadenectomy, the portal vein, proper hepatic and common hepatic arteries were dissected. Branch arteries to segments II, III and IV were ligated. The parenchyma was divided after left portal vein clamping. EBL was 400 cc with 220 min operative time. LOS was 48 h. Pathology confirmed a T1N0M0 moderately differentiated cholangiocarcinoma with negative margins.
LAPAROSCOPIC SIGMOID RESECTION FOR COLO-VAGINAL FISTULA DUE TO DIVERTICULAR DISEASE WITH FLUORESCENT URETER IDENTIFICATION

Luigi Boni, MD, FACS; Elisa Cassinotti, MD, PhD; Massimiliano Della Porta, MD; Ludovica Baldari, MD; Fondazione IRCCS Ca’ Granda Ospedale Maggiore Policlinico di Milano.

This video shows laparoscopic sigmoid resection for colo-vaginal fistula due to diverticular disease. Immediately before surgery, the patient underwent endoscopic placement of left ureteral catheter. A 25 mg indocyanine green (ICG) vial was diluted with 20 ml of steril water, and 3 ml of this solution were injected through the ureteral catheter. After partial retraction of ureteral catheter, ICG fluorescence allowed visualization of left ureter along surgery, avoiding injuries. After colonic mobilization, the vaginal fistula was confirmed and closed with interrupted sutures. The sigmoid colon was resected and colo-rectal anastomosis was fashioned after bowel perfusion control through ICG fluorescent angiography.

Robotic Small Bowel Strictureplasty

Elizabeth R Raskin, MD, FACS, FASCRS; University of California Davis.

This video demonstrates the robotic technique for small bowel strictureplasty. Our patient is a 54-year old male with a history of chronic ulcerative colitis who underwent a total proctocolectomy with ileal pouch anal anastomosis and diverting loop ileostomy. The patient underwent a subsequent ileostomy takedown. 5 years later, he developed a small bowel obstruction that was identified as the site of his ileostomy takedown. No evidence of Crohn’s disease was seen. A robotic Heinecke-Mikulicz strictureplasty was performed. Step-by-step detail of the procedure is shown. The patient recovered uneventfully from the procedure and discharged home on postoperative day #2.

LAPAROSCOPIC EXCISION OF PELVIC SCHWANNOMA

Emanuela S Alvarenga, MD; Ilana G Setton, MD; Sandra Kavalukas, MD; Steven D Wexner, MD, PhD, Hon, FACS, FRCS, Eng, FRCSed; Giovanna DaSilva, MD, FACS, FRCS; Cleveland Clinic Florida.

This video depicts a laparoscopic approach of a pelvic schwannoma incidentally found in this 48-year-old male during work up for left lower quadrant pain, including CT scan of abdomen and pelvis for presumable diverticulitis. Patient was positioned in the modified lithotomy. Through a 10 mm supraumbilical, and three additional 5 mm trocars at the right upper, lower and left flank, the sigmoid was mobilized, the presacral space was entered, the rectum was mobilized, and the mass was dissected out of the left lateral mesorectum. There were no perioperative complications. Specimen pathology confirmed schwannoma.

Laparoscopic Trans-Gastric resection of GIST tumour near the Oesophageo-gastric Junction

Hiba A Shanti, MD; Ameet G Patel, FRCS; King’s College Hospital.

Bleeding is the most common presentation of Gastric GIST. Location near the GEJ necessitate extensive resection. Our patient was diagnosed with upper lesser curvature 6 cm GIST tumour and was treated with Imatinib as he was considered high risk for surgery due to co-morbidities; T2DM, HTN, ESRD and Multiple myeloma. He is on Dual antiplatelet therapy for TIAs, and Rivaroxiban for arrhythmias. He presented with recurrent attacks of Bleeding requiring transfusion and has failed Endoscopic treatments. We performed a laparoscopic transgastric resection of the tumour with clear margins. He recovered well and has completed one-year with no recurrence or bleeding.
To scope or NOT to scope? Wedge resection of Incidentally diagnosed Schwannoma
Lucman A Anwer; Shadi Aboudi; Andres Giovannetti; Fadi Dahdaleh; George Salti; Rami Lutfi; UIC/MGH; Edward Surgical Oncology Group; UIC.
Routine preoperative endoscopy before bariatric surgery remains a controversial topic. Herein, we present a case of an incidentally diagnosed gastric Schwannoma on pre-op endoscopy, before planned bariatric surgery. Routine pre-op endoscopy can help identify incidental lesions and aid in surgical decision making. Furthermore, intra-op endoscopy at the time of surgery is also an invaluable tool; not only to test the anastomosis at the end, but also to help guide adequate surgical resection.

Complete Laparoscopic Resection of a Large Mesenteric Cyst
Colleen Donahue, MD; Dmitry Nepomnayshy, MD; David Brams, MD; John H Stroger Jr Hospital of Cook County; Lahey Hospital and Medical Center.
This video presents a case a complete laparoscopic excision of a benign mesenteric cyst. This young, otherwise healthy patient presented to our emergency department with central abdominal pain. Workup, including CT and MRI, revealed a 6.5 cm thick walled cyst within the small bowel mesentery containing fat and fluid. She was taken to the operating room for laparoscopic excision. Once excised, there was evidence of small bowel ischemia, therefore a small bowel resection was performed. The cyst was removed via a small Pfannenstiel incision. Pathology revealed a benign chylous containing mesenteric cyst. She was discharged to home on post-operative day one.

Laparoscopic Robot Assisted Repair of Colotomy After Iatrogenic Colonic Perforation: A Case Series
Claire L Terez, MD; David Palange, DO; Adam Smith, MD; David Weithorn, MD; Adam Rosenstock, MD; George Mazpule, MD; Stephen Pereira, MD; Rutgers New Jersey Medical School; Hackensack University Medical Center.
Iatrogenic colonic perforation during colonoscopy is a rare complication that occasionally will require general surgery intervention. We present three cases where these colonic injuries were managed using a laparoscopic, robot assisted approach. The first case was managed with primary tissue repair. The second case was managed with primary repair as well as a diverting ostomy. The third case required a right hemicolectomy given the location of the injury and their underlying pathology. Each case exemplifies the ease of laparoscopic suturing when using the robotic platform as well as the feasibility of using robotic technology in emergency general surgery.

A Novel “SANDWELL SANDWICH” Approach to Perineal Hernia Reconstruction—Video Presentation
Adil N Ahmad, MBBS, BSC, MRCS; Kiran Dhaliwal, MBChB, MRCS; Rajeev Peravali, MBChB, FRCS; Atul Khanna, MBBS, FRCS; Sandwell and West Birmingham NHS Trust.
INTRODUCTION: This video demonstrates a novel approach to surgical repair of a perineal hernia in a patient with previous Abdomino-Perineal Resection and radiotherapy. METHODS AND PROCEDURES: Instead of using an intra-peritoneal biological mesh, we kept the sac intact, reduced, and then invaginated it with a layer of dermis and visceral peritoneum. An extra-peritoneal polypropylene mesh was fixed onto the pelvic rim using Protac. A gluteal muscle sling was created superiorly, dermal sling inferiorly and a covering v–y flap. RESULTS: Successful outcomes with reduced pain and no recurrence after 6 months follow-up. CONCLUSION: This “Sandwich” technique solves a complex clinical problem.
Gastrointestinal Stromal Tumor within Hiatal Hernia Causing Obstruction: A Case Report

Joseph M Youssef, DO; Michael T Fastiggi, MD; Mujahid Abbas, MD; Leena Khaitan, MD, MPH; UH Cleveland Medical Center.

This is a case presentation of a 62F with a known hiatal hernia who presented with obstructive symptoms. She was shown to have a gastrointestinal stromal tumor within the herniated portion of a paraesophageal hiatal hernia that caused intermittent obstruction. She underwent laparoscopic partial gastrectomy, hiatal hernia repair and roux-en-y reconstruction. An overview of her work up including her EGD and the surgical decision making during the surgery is presented in this abstract.

Laparoscopic Duodenojejunostomy for Superior Mesenteric Artery Syndrome

Rahul Singh, MBBS, MS, FNB, Minimal Access Surgery; Ashish Dash, MBBS; Vivekananda Polyclinic & Institute of Medical Sciences.

In SMA syndrome, the AortoMesentericAngle(42.4) is reduced to < 22degrees, and the AortoMesentericDistance(10-28 mm) reduced to < 8 mm. Patient had post-prandial bilious-vomiting & weight-loss. CECTscan and UGIE confirmed the diagnosis. Patient planned for Laparoscopic Duodeno-jejunostomy. 4 Ports placed with surgeon standing on left. The transverse colon was reflected cranially exposing the root of mesentery and DJ flexure. Peritoneum over proximal D-3 divided and c-loop of duodenum mobilized. A stapled 45 mm, white(2.5 mm) antiperistaltic side to side Duodeno-Jejunostomy was created 30 cm from DJ-flexure with hand sewn enterotomy closure. Under water air insufflation test done and patient started on liquids following gastrograffin study on POD-2.

Laparoscopic RYGB Reversal for Secondary Oxalate Nephropathy

Sam Grasso, DO1; Benjamin Clapp, MD2; Andres Vivar, BS3; 1William Beaumont Army Medical Center; 2Texas Tech HSC Paul Foster School of Medicine; 3Universidad Autonoma de Guadalajara.

This video highlights a case of oxalate nephropathy after RYGB. Post-operatively, the patient developed secondary oxalate nephropathy, causing further renal damage leading to end stage renal disease (ESRD). The patient is being evaluated for renal transplant. However, the decision was made by the patient, his nephrologist, and his bariatric surgeon to reverse his bypass so as to prevent further nephropathy. Our video demonstrates LRYGB reversal in a laparoscopic fashion. Reversal of gastric bypass can play a role in the management of the otherwise devastating, but rare, complication of secondary oxalate nephropathy.

Endoscopic Gastrogastrostomy Revision

Jennifer Colvin, MD; Sabrena Noria, MD, PhD; Bradley Needleman, MD; Ohio State University Wexner Medical Center.

A 48 year old female with a remote history of roux-en-Y gastric bypass and subsequent reversal and gastrostomy tube placement presented with a gastrocutaneous fistula and gastrogastrostomy stenosis, which required repeat dilations and stenting. She presented for definitive management of the stricture and closure of the fistula. A 12 mm trocar was used to access the stomach under endoscopic visualization. The gastrogastrostomy was then revised by firing a stapler across the stenotic gastrogastrostomy, with one jaw of the stapler placed in the proximal pouch. Post-operatively, the patient was able to tolerate a diet and was discharged home.
Massive Paraesophageal Hernia repair combined with Roux En Y Gastric Bypass: An Avenue for Decreasing Recurrence and Improving Post-operative GERD

Alec Bigness; Joseph A Sujka, MD; Karla Bernardi, MD; Chris G DuCoin, MD; University of South Florida.

A 51-year-old female presented to us with morbid obesity and significant GERD. She was found to have a massive paraesophageal hernia on EGD with most of the stomach in the left chest. We brought her to the OR for Robotic assisted Hiatal hernia repair with mesh and Roux En Y Gastric Bypass. Post operatively the patient did well and after UGI was allowed to eat. Her reflux symptoms resolved and she was discharged home post-op day #2. RYGB increased our operative time but eliminates GERD in patients with massive paraesophageal hernias and may decrease recurrence.

Laparoscopic Caudate Lobe Resection: Steps and Video Presentation

Ibnouf Sulieman, MD, MSc; Walid Elmoghazi, MD, PhD; Aamer Has-san, MD; Jawhara Al-Qahtani; Ammar Aleter; Ahmed Elaffandi, MD; Hatem Khalaf, MD, PhD; Hamad Medical Corporation.

This is a video presentation of a laparoscopic caudate lobe resection, highlighting and demonstrating the major steps of the surgery. The patient is a young male patient with colorectal liver metastases from adenocarcinoma of the sigmoid colon. He had two lesions, one in the right lobe and one in the caudate lobe. Here we present the steps of the laparoscopic caudate lobe liver resection.

Laparoscopic Revision of Gastric Bypass Reversal

Caitlin Polistena¹; Raul Rosenthal²; ¹Precision Surgical Specialists of Lowell; ²Cleveland Clinic Florida.

This is a presentation of a 59 year old female with a complicated surgical history. She underwent RYGB in 2002 for morbid obesity and subsequently required multiple bowel resections leaving her with < 250 cm of small bowel and a sigmoid colon. In 2006 her bypass was reversed due to the consequences of her shortened gastro-intestinal tract. She later developed PO intolerance with weight loss. Workup revealed contrast pooling in the distal part of the original gastric pouch. Given these findings and persistent PO intolerance it was felt that the patient may benefit from a procedure to facilitate emptying of the pouch.

Laparoscopic Reduction of Intussusception Following Roux en y Gastric Bypass

Colston Edgerton, MD¹; David Spector, MD²; ¹Medical University of South Carolina; ²Brigham and Women's Hospital.

We present the case of a 37 year old female with a history of Roux en Y Gastric Bypass who presented with a large obstructing intussusception at the jejunojejunostomy. This was successfully addressed via laparoscopic reduction. Technical tips are presented to facilitate performing this procedure laparoscopically and avoiding bowel injury.
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Robotic repair of a Traumatic Diaphragmatic Hernia with Mesh

Tyler R Petree; Abubaker Ali, MD; Lindsey Nelson, DO; DMC Sinai-Grace.

This video shows the repair of an acute traumatic diaphragmatic hernia using the robotic platform. Previous studies have shown the efficacy and safety of laparoscopic repair of acute traumatic diaphragmatic hernias and others have shown the successful use of the robotic platform for chronic traumatic diaphragmatic hernias. This video is the first show the safety and efficacy of the robotic platform in the repair of an acute traumatic diaphragmatic hernia.

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Ureter Containing Right Inguinal Hernia

Brandon C Dessecker, MD; Katelyn Mellion, MD; Chris Hofland, MD; Brandon Grover, DO, FACS, FASMBS; Gundersen Health System.

Our video details a case of a patient with a large right inguinal hernia, which contained a large amount of retroperitoneal fat as well as the patient's right ureter. He suffered from recurrent pyelonephritis and ureteral stones due to his attenuated ureter and stasis. He underwent a mesh based robotic hernia repair with ureteral re-implantation.

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Minimally Invasive Ivor-Lewis Esophagectomy with Trans-hiatal Esophageal Transection and Manually-Reinforced Stapled Esophago-Gastric Intrathoracic Anastomosis for Siewert II Esophageogastric Cancer

Giorgio Dalmonte, MD; Alfredo Annicchiarico, MD; Marina Valente, MD; Francesco Tartamella, MD, PhD; Federico Marchesi, MD, PhD; Unit of General Surgery, Parma University Hospital.

The minimally invasive approach for Ivor-Lewis technique is still a challenge, mainly for the technical difficulties in intrathoracic anastomosis. In the video we show our approach for minimally invasive esophagectomy. Trans-hiatal esophageal resection allows an easy transabdominal specimen extraction and frozen section examination. During thoracoscopy in prone position, after completing mediastinal node dissection and further resecting the esophageal stump when necessary, we usually perform a stapled esophago-gastric intrathoracic anastomosis, with manual staple-line reinforcement using a single-layer technique with a 2–0 barbed suture.

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Gastric Sleeve Conversion to Roux-En-Y Gastric Bypass

William C Sherrill, MD; Angela Lee, MD; Shaina Eckhouse, MD; Washington University in St. Louis.

Our video depicts a patient with a previous sleeve gastrectomy while on a LVAD, who developed severe acid reflux after her combined heart and kidney transplant results in inability to tolerate her oral anti-rejection medications. Pre-operatively she was diagnosed with reflux and a hiatal hernia. After optimization she underwent a laparoscopic partial gastrectomy with Roux-en-Y reconstruction and a hiatal hernia repair. Post-operatively the patient is now tolerating her oral medications without issues and is no longer in danger of rejection. This case depicts the importance of multidisciplinary and long-term follow up for the bariatric surgery population.
Trans Oral Removal of Silastic Band in the setting of Gastric Bypass and multiple abdominal surgeries
Michelle Lippincott, MD; Michelle McGee, MD; Joseph A Sujka, MD; Ali Abbas, MD; Chris G Ducoin, MD; University of South Florida.

This is a 51-year-old female who who underwent Foreign body transection and removal via Natural Orifice Transluminal Endoscopy (NOTES) via EGD for an eroded silastic gastric band and a history of gastric bypass. She presented with a PMHx of upper GI bleed with findings of an eroded gastric band after previous gastric bypass surgery. Due to her multiple previous surgeries we decided to first attempt removal via endoscopy and convert to robotic if this was unsuccessful. We successfully removed this band endoscopically without having to perform revisional surgery and present our case and it’s findings.

Fundus Lift Technique For Difficult Laparoscopic Cholecystectomy.
Samer Zino, MD, MRes, PhD, FRCS; NineWells Hospital/ Dundee.

This video Presents a technique that helps in achieving adequate and safe retraction of inflamed or normal gallbladder over a heavy-fatty liver, hence improve visualisation of hepatocystic triangle.
Fundus Lift technique starts with dissecting the fundus of the gallbladder from the liver bed through the submucosal plane for 2-4 cm. Freeing the fundus will allow lifting it along with the gallbladder over the liver-edge to achieve adequate retraction of the GB toward the right shoulder avoiding heavy fatty liver resistance.
Funds lift will help in bringing the hepatocystic triangle into view and facilitate safe dissec-
tion toward achieving Critical view of safety.

Robotic Transabdominal Preperitoneal Repair of Intraabdominal Chest Tube Site Hernia with Mesh
Keval R Tilva, MD; Krzysztof Wikiel, MD; Edward L Jones, MD; University of Colorado.

Introduction: We present robotic repair of a symptomatic intraabdominal chest-tube hernia site.
Case description: A 36 year old male developed left lower chest pain and bulging after complicated pneumonia. A left upper quadrant hernia between left eighth and ninth ribs was confirmed on CT scan.
Technique: Patient was placed supine with left chest bumped. Three trocars were placed and robot was docked. A preperitoneal flap was created and hernia was reduced. The defect was approximated, mesh was placed, and the peritoneal flap was replaced.
Conclusion: Robotic surgery allows for effective repair of difficult hernias with mesh placement into preperitoneal space.

Laparoscopic Repair of Iatrogenic Diaphragmatic Hernia
Alia AlHareb, MD; Mohammed Abdallah, MD; Yaqeen Qudah, MD; Juan Barajas Gamboa, MD; Gabriel Diaz Del Goboo, MD; Carlos Abril, MD; Javed Raza, MD; Richard Corcelles, MD; Matthew Kroh; Cleveland Clinci Abu Dhabi.

Diaphragmatic hernias are rare complications of abdominal surgery. This is a case of a 63-year-old male who came in with recurrent episodes of left upper quadrant pain and bloating. He had underwent multiple upper gastrointestinal surgeries in the past. A computed tomography (CT) scan was performed showing Focal defect in the left anterior diaphragm with herniation of the part of the splenic flexure of colon. The diaphragmatic defect was pre-
sumed to be iatrogenically acquired after his multiple surgeries in the past. Our patient under-
went a laparoscopic diaphragmatic hernia repair with mesh. He made an uneventful recovery.
Laparoscopic D2 Subtotal Gastrectomy with Intracorporeal Roux-en-Y Reconstruction for T4 Distal Gastric Adenocarcinoma

Cristiano Parise, MD; Elisa I Bottazzoli, MD; Enrico Ferri, MD; Nicola De Angelis, MD; Shameen Jaunoo, MD; Lu Demin, MD; Giuseppe Ietto, MD; Domenico Iovino, MD; Valentina Iori, MD; Federica Masci, MD; Giulio Carcano, MD; Salomone Di Saverio, MD, FACS, FRCS of England; 1University of Insubria, Varese; 2Université Paris-Est Créteil, Paris; 3St. Bartholomew’s & The Royal London School of Medicine; 4Zhejiang University Hangzhou, Zhejiang, China; 5Royal College of Surgeons of England

56-years-old woman, presenting with persistent epigastric pain and dyspepsia. EGD showed irregular thickening of gastric antrum mucosa, rigid infiltrated ulceration involving great curvature and posterior wall of the stomach. I.E.: gastric adenocarcinoma. Abdomen CT-scan: thickening of gastric antrum walls pathological lymph nodes adjacent to the great curvature, antrum and fundus. cT4,N + MDT discussion recommended neoadjuvant chemotherapy, performed (Cysplatin + 5-FU) with partial response. The patient underwent totally laparoscopic sub-total (95%) gastrectomy with D2-limphadenectomy and reconstruction with transmesocolic Roux-en-Y with intracorporeal gastrojejunal anastomosis. LOS 6-days. Histology: adenocarcinoma intestinal type, G3, pT4a, pN3a (7+/29). Neoadjuvant chemo-radiotherapy was performed. 3-years follow-up (OGD, CT and PET-Scan) no gastric or distant recurrent disease.

Laparoscopic Conversion of Aspiration Therapy to Sleeve Gastrectomy

Michel Gagner, MD, FRSCS, FACS, FASMBS; Maxime Lapointe-Gagner, BS; Westmount Square Surgical Center.

Aspiration therapy by percutaneous endoscopic gastrostomy (PEG) is an alternative, reversible treatment for patients who decline bariatric surgery for weight loss. On average, the use of PEG devices leads to 40–50% EWL, but approximately one-quarter of patients cease using the device. We present the laparoscopic conversion of aspiration therapy to sleeve gastrectomy in a 50-year-old male whose weight loss stagnated in the year following aspiration therapy. Key elements of the surgery are: disconnection of the stomach to the abdominal wall, ligature of numerous gastro-epiploic branches, use of higher staple height, and lateral pushing (greater curvature) of the PEG device.

Endoscopic Rendezvous Procedure to Treat Colorectal Anastomotic Closure

Meridith Ginesi, MD; Meagan Costedio, MD; 1University Hospitals UHRISES; 2University Hospitals

This video presents an endoscopic rendezvous procedure performed for closure of a colorectal anastomosis. The patient had undergone a laparoscopic converted to open sigmoidectomy with diverting loop ileostomy for perforated diverticulitis, with feculent peritonitis. Afterwards, despite dilation, the anastomosis strictured until it had completely closed. This technique uses fluoroscopy and endoscopy to safely open the anastomosis without surgical revision of the anastomosis.

Blood Bezoar: an Unusual Complication after Conversion Sleeve Gastrectomy to Roux-en-Y Gastric Bypass

Christine Tat, MD; Juan S Barajas-Gamboa, MD; Gabriel Diaz Del Gobbo, MD; Carlos Abril, MD; Javed Raza, MD; Ricard Corcelles, MD; Matthew Kroh, MD; Cleveland Clinic Abu Dhabi.

52-year-old female with history of sleeve gastrectomy underwent revisional roux-en-y gastric bypass (RYGB) for reflux. Post-operatively patient developed a leak. She was taken back to the OR and was found to have a blood bezoar in the common channel causing an obstruction, thus leading to a leak at the jejunojejunostomy. This video demonstrates an unusual complication after revisional RYGB. Patient did well after the re-operation. In conclusion, blood bezoar is an unusual complication after RYGB. Although gastrojejunostomy leaks are more common than jejunojejunostomy leaks, it is important to always consider it.
Robotic Median Arcuate Ligament Release
Patrick Dolan, MD; Victoria Aveson, MD; James Senturk, MD; Sharif Ellozy, MD; Cheguevara Afaneh, MD, FACS; Omar Bellorin, MD, FACS; NYP-Weill Cornell Medical College.

Introduction: Median Arcuate Ligament Syndrome is a rare clinical entity in which the celiac artery is compressed by the median arcuate ligament, resulting in severe abdominal pain and weight loss.

Case: Peritoneal access was obtained and robotic trocars placed. The pars flaccida was entered. The left gastric artery was isolated and retracted caudally. Lymphatic tissue was bluntly dissected free from the celiac artery and cauterized, exposing the median arcuate ligament. The transverse fibers overlying the celiac artery were divided, and this dissection was carried superiorly along the aorta. Dividing these fibers relieves the compression of the celiac artery.

Laparoscopic Repair of Iatrogenic Left Diaphragmatic Hernia
David Leenen, MD1; Marcoandrea Giorgi, MD2; 1Rhode Island Hospital/Brown University; 2Miriam Hospital/Brown University.

We present the case of a 55 year old woman with an iatrogenic left diaphragm hernia. The patient underwent an open aortic surgery five days earlier which required supra-celiac control. The vascular surgeon inadvertently created a defect in the diaphragm intra-operatively. The patient became septic on post-operative day five and imaging revealed her stomach had herniated into her chest with contrast extravasation. She underwent laparoscopic repair of the diaphragm hernia, partial gastrectomy and left chest tube placement. She passed an upper gastrointestinal study on post-operative day two and was started on a diet. The chest tube remained for thirty days.

Endoscopic Removal of LINX Device, Laparoscopic Redo Hiatal Hernia Repair, Roux-en-Y Gastrojejunostomy, Feeding Jejunostomy Tube Placement
Ying Ming B Tan, MD1; Marissa Mendez, MD2; Mohamed R Ali, MD2; Victoria Lyo, MD2; 1San Joaquin General Hospital; 2University of California Davis.

We present a case of a 69-year-old woman with an eroded LINX and dysphagia. After paraesophageal hernia repair and LINX placement in 2016, with recurrence of her hernia on POD1 requiring reduction of the incarcerated stomach and PEG gastrostomy, she underwent multiple endoscopic dilations by gastroenterology for dysphagia. She was found to have an eroded LINX device and recurrent hiatal hernia with severe weight loss and gastroparesis. We performed an endoscopic removal of the LINX device, laparoscopic redo-hiatal hernia repair, gastric division with Roux-en-Y gastrojejunostomy, and feeding jejunostomy tube placement. The patient recovered well, is tolerating food and gaining weight.

Robotic Inguinal Hernia Repair After Prostatectomy
Diego L Lima, MD1; Ruben D Salas-Parra, MD2; Xavier Pereira, MD1; Flavio Malcher, MD, MSc1; 1Montefiore Medical Center; 2Bronxcare Health System.

We aim to outline a robotic-assisted inguinal hernia repair technique in a patient with previous prostatectomy. A 75 years-old patient, BMI of 27.5 kg/m² and previous robotic prostatectomy due to cancer 2 years ago. This technique differs from the standard TAPP inguinal repair. Due to the fibrosis from the previous bladder dissection, this dissection is laborious and should be carefully performed. Fibrosis from previous lymphadenectomy may alter the anatomy from the area and the dissection of this area may lead to an injury of a major vessel. The patient was discharged in the same day with no further complications.
V236

Laparoscopic Ladd’s Procedure for Adult Presentation of Intestinal Malrotation

Rory Carroll; Oscar Talledo; Peter Nau; University of Iowa Hospitals and Clinics.

Intestinal malrotation classically presents in infants as a surgical emergency. Rarely it can be found in the adult population with variable symptomatology. Herein is a case of a 23-year-old male who presented with acute right lower quadrant pain and an incidental finding of intestinal malrotation on CT scan. He was initially treated non-operatively and the presenting symptoms resolved. Following the resolution of his complaints, he underwent an elective laparoscopic Ladd’s procedure. He was discharged on post-op day one. In follow-up the patient reported that the operation had resolved chronic gastrointestinal complaints that he previously attributed to normal postprandial bowel habits.

V238

Laparoscopic Retrocrural Lymph Node Biopsy

Laura Meiler; Christian Massier, MD; Cleveland Clinic.

This is a video of a laparoscopic retrocrural lymph node biopsy. There are few reports within the literature that describe a robotic approach. This video will demonstrate that a laparoscopic approach can be safe and feasible at a cheaper cost compared to the robot. Our patient was a 76 year old male with a past medical history of Non-Hodkins lymphoma. On a screening CT scan there was noted to be a retrocrural lymph node that was not amendable to percutaneous biopsy. A tissue diagnosis was requested for possible initiation of chemoradiation.

V237

Laparoscopic Heller myotomy and Conversion of Vertical Banded Gastroplasty to Roux-en-Y gastric Bypass

Daniel C Sprando, MD; Jason Lamb, MD; Nova Szoka, MD; Lawrence Tabone, MD; Salim Abunnaja, MD; West Virginia University.

We present a case of a 71 year-old female with a history of vertical banded gastroplasty (VBG) in 1988 for obesity who was complaining of a two year history of worsening dysphagia and chronic nausea/vomiting. Her evaluation consisted of upper GI study, manometry and upper endoscopy, which revealed evidence of achalasia, as well as partial obstruction at the VBG outlet. The patient underwent laparoscopic Heller myotomy to address the patient’s achalasia in conjunction with conversion of VBG to Roux-en-Y gastric bypass to address any possible VBG outlet obstruction. The procedure was well-tolerated and resulted in complete resolution of symptoms.

V239

Robotic Pancreaticoduodenectomy: Trocar Placement and Switching

Jordan N Robinson, MD, MPH; Dionisios Vrochides, MD, PhD; John Martinic, MD; Atrium Health.

Pancreaticoduodenectomy represents a massive undertaking for patients and surgeons alike. It is a highly morbid and minimally-invasive approaches are infrequently attempted due to the technical and ergonomic challenges required for its safe and effective execution. Features of the robotic surgical platform attenuate several difficulties inherent to the laparoscopic approach making a minimally-invasive approach feasible for the experienced robotic surgeon. As with laparoscopy, thoughtful and ergonomic trocar placement can greatly decrease the procedure’s difficulty. In this original video, we detail the technical considerations of trocar placement and switching using a five-port arrangement to facilitate ergonomic movement and to minimize patient morbidity.
Sleeve Gastroctomy with a Single Stapler Firing: Our Technique Using a Novel Device in a Live Porcine Model

Syed A Karim, MD; Arianne Train, DO, MPH; Christina M Sanders, DO; Steven D Schwaitzberg, MD; Aaron B Hoffman, MD; University at Buffalo.

During sleeve gastrectomy, the degree of pouch variability introduced by successive stapler firings may induce postoperative complications. A novel gastric stapler completes an extended gastrectomy in a single firing, utilizing a distal fulcrum and three rows with varying staple heights. We demonstrate our technique in a live porcine model. There were no stapler malfunctions in 8 cases. Surgeon evaluation of device performance was excellent overall. Visual inspection reveals uniform, hemostatic staple lines with well-formed staples. The Titan SGS provides a simple and feasible method of performing sleeve gastrectomy in a single firing, potentially avoiding complications related to overlapping staple lines.

Laparoscopic Management of Gallstone Ileus

Helen Y Ho, MD1; Michelle E Chang, MD1; Chaitan Narsule, MD2; Iman Ghaderi, MD3; University of Arizona; 4Lahey Hospital & Medical Center.

In this video, we demonstrate two laparoscopic approaches in the management of gallstone ileus. The first case demonstrates a totally laparoscopic approach and the second case demonstrates a laparoscopic-assisted approach.

Robotic Single-Anastomosis Duodenoeileal Bypass After Sleeve Gastrectomy For Insufficient Weight Loss

Yilon Lima Cheng, MD; Domenech Asbun, MD; Enrique F Elli, MD; Mayo Clinic Florida.

We report the case of a 62-year old patient who underwent laparoscopic sleeve gastrectomy for morbid obesity. BMI decreased from 67 to 61 kg/m2. Due to further difficulty losing weight and to multiple comorbidities, decision was made to convert the sleeve to a single-anastomosis duodenoeileal bypass. Surgery was performed using the robotic platform. The duodenum was transected about at the second portion. Indocyanine green was used to evaluate the vascular supply of the duodenal stump. A two-layered antecolic end-to-side handsewn anastomosis was constructed, measured 250 cm distant to the ileocecal valve. Postoperative period was unremarkable.

PUSHING THE BOUNDARIES OF TAMIS. Transanal Minimally Invasive Surgery (TAMIS) Resection of a Very Large Circumferential Rectal Polyp with a Combined Laparoscopy for a Synchronous Right Colon Le

Andrea Scardino, MD1; Vincenzo Pappalardo, MD1; Patricia Tejedor, MD, PhD2; Rahila Essani, MD3; Akinfemi Akingboye, MD, FRCS of England4; Alice Frontali, MD5; Monica Ortenzi, MD6; Pierpaulo Sileri, MD7; Francesca Magnoli, MD5; Mario Guerrieri, MD5; Fausto Sessa, MD6; Salomone Di Saverio, MD, FACS, FRCS of England1; 1Department of General Surgery 1, Ospedale di Circolo, University of Insubria, ASST Sette Laghi, Varese; 2Department of Colorectal Surgery, University Hospital ‘Gomez Ulla’, Madrid; 3Department of Surgery, Baylor Scott and White Health, Temple, Texas; 4General Surgery Department, Russells Hall Hospital, The Dudley Group Hospitals, West Midland, UK; 5General Surgery 2, Ospedale Luigi Sacco, University of Milan, Milano; 6Department of General and Emergency Surgery, Politechnic University of Marche, Ancona; 7Vice Minister of Health, Italian Government, Rome, Italy; 8Unit of Pathology, Department of Medicine and Surgery, University of Insubria, ASST dei Sette Laghi, Varese.

The Colorectal Cancer screening is revealing an increasing number of large precursor lesions, for which local excision may be the optimal treatment. However, the choice whether to perform it and with which technique is still unclear, especially where Endoscopic Submucosal Dissection is rapidly spreading. We advocate the use of laparoscopic technique together with Transanal Minimally Invasive Surgery (TAMIS) as a combined approach for an 80-year-old patient with both a colonic and bulky rectal adenoma. TAMIS is indicated for treatment of benign rectal lesions (adenoma), and it can be performed when the patient is unfit for two synchronous major resections.
Laparoscopic Hiatal Hernia Repair of Gastrojejunostomy

Ammar Humayun, MD; Sirivan S Seng, MD; Sergey Zhitnikov, MS; Aley Tohamy, MD; Crozer Chester Medical Center.

This case involves a 67-year-old female with a BMI of 32.6 and a remote history of gastric bypass presenting for dysphagia and reflux. Upon further imaging, migration of the gastric pouch and an incarcerated gastroesophageal junction just above the hiatus was confirmed. She subsequently underwent laparoscopic hiatal hernia repair of the gastrojejunostomy. Given the morbidity of this second operation, which included time under anesthesia, significant dissection around diaphragm, and financial burden, this could have been potentially avoided if the patient undergone hiatal hernia repair upon her index surgery.

Robotic Repair of Giant Type IV Paraesophageal Hernia with Toupet Fundoplication and Partial Hepatectomy

Britta Han, MD, MSEd; Arnab Majumder, MD; Sara E Holden, MD; Barnes Jewish/WashU in St Louis.

This is an operative video submission of a robotic repair of a giant type IV paraesophageal hernia with Toupet fundoplication and partial hepatectomy. This operative video demonstrates the repair of a complex giant type IV paraesophageal hernia. The case is unique for several reasons. First, the patient is a 35 year old female with cerebral palsy and severe scoliosis who is wheelchair bound, which notably limited the working intra-abdominal space. Second, the paraesophageal hernia was a giant type IV with the hernia sac containing stomach, splenic flexure, transverse mesocolon and tail of pancreas.

Local Block for Open Inguinal Hernia Repair

Sullivan A Ayuso, MD; Bola G Aladegbami, MD; Vedra A Augenstein, MD; B T Heniford, MD; Carolinas Medical Center.

At Carolinas Medical Center, elective open inguinal hernia repairs are performed using a local block and IV sedation. The technique for the local block is presented in this video. A mixture of quarter percent Marcaine and one percent lidocaine are used for the block. Injection of the local anesthetic is performed along the site of the inguinal incision. The skin is anesthetized and then the local is injected down to, and through, the external oblique fascia. As a result, the iliohypogastric nerve and the spermatic cord are also anesthetised. The patient tolerates the procedure well and is discharged home.

Hybrid Laparoscopic Repair of Parastomal Hernia with Subcutaneous Ileostomy Prolapse

Sean Maroney; Syed Husain; The Ohio State University Wexner Medical Center.

Subcutaneous ostomy prolapse occurs when the bowel slides above the fascia into the subcutaneous tissue. This can lead to obstruction, discomfort and abdominal wall deformity. This video demonstrates a combination open mobilization of a parastomal hernia with laparoscopic intraperitoneal mesh placement using the Sugarbaker technique. This patient had an excellent postoperative outcome with no hernia recurrence at the one year follow-up appointment.
Fluorescence Guided Minimally Invasive Laparoscopic Thoracoscopic Ivor Lewis Esophagectomy

Sinal Patel, MD; George Tadros, MD; Bakhtawar Mushtaq, MD; Shubham Bhatia, MD; Francisco X Franco, MD; Emanuele Lo Menzo, MD, PhD, FACS, FASMBS; Samuel Szomstein, MD, FACS, FASMBS; Raul Rosenthal, MD, FACS, FASMBS; Cleveland Clinic Florida.

Esophageal cancer represents 1% of all cancers diagnosed in the US. We present the case of a 60-year-old male scheduled for surgery for esophageal adenocarcinoma after neoadjuvant chemotherapy. The abdominal stage started with skeletonizing the greater curvature of the stomach using an ultrasonic dissector, followed by circumferential hiatal dissection. The gastric conduit was then created using linear stapler. ICG angiography was performed to assess graft’s perfusion. The thoracic stage was done with mobilization of distal esophagus to the level of the azygous vein. End-to-side esophagogastrotomy was performed using a circular. The patient tolerated the procedure well with uneventful recovery.

Robotic Assisted Cholecystectomy with ICG Cholangiography and Subtotal Fenestrated Excision of a Type II Choledochal Cyst

Genevieve Gill-Wiehl, MD, MPH; Benjamin Veenstra, MD; Scott Schimpke, MD; Rush University Medical Center.

This case report highlights a safe approach in a patient with unusual biliary anatomy. The patient had a previous episode of pancreatitis and represented with abdominal pain and elevated liver enzymes. He was found to have chronic cholecystitis and a suspected choledochal cyst. In the operating room, a robotic assisted approach with ICG cholangiography was used to identify the type II choledochal cyst and perform a subtotal fenestrated cyst excision and cholecystectomy as the cyst was fused to both the cystic duct and common bile duct and complete excision would have required a common bile duct reconstruction.

Laparoscopic Management of Median Arcuate Ligament Syndrome in a Patient with Crohn’s Disease

Paul Perales, MD; Luis F Okida, MD; Matthew Wolfers, MD; Vanessa Ale, MD; Mark Grove, MD; Emanuele Lo Menzo, MD, PhD, FACS, FASMBS; Samuel Szomstein, MD, FACS, FASMBS; Raul J Rosenthal, MD, FACS, FASMBS; Cleveland Clinic Florida.

Laparoscopic release remains the main treatment of Median arcuate ligament syndrome (MALS). We present a case of a 34-year-old female with history of Crohn’s disease presenting with postprandial epigastric pain. After trocars placement, the lesser sac was entered by dividing the pars flaccida, and the right diaphragmatic crus was identified. Upon hiatal dissection, a window behind the esophagus was created. Dissection at the takeoff of the common hepatic artery and left gastric artery was obtained. The right diaphragmatic crus was divided over the aorta with division of the median arcuate ligament and nerve fibers. The patient made an uneventful recovery.

Robotic Excision of Type I Choledochal Cyst with Roux-en-Y Reconstruction

Usman Y Panni, MD; Dominic E Sanford, MD, MPHS; Washington University in St. Louis.

In this video abstract, we present a robotic excision of type I choledochal cyst with roux-en-Y reconstruction. Our patient was a 31-year-old female with a history of recurrent epigastric pain and an episode of pancreatitis. The imaging studies showed a type I choledochal cyst with no intrahepatic duct dilatation. Operatively, we dissected the cyst/common bile duct complex and stapled the distal end across normal appearing common bile duct. We divided the superior aspect of the cyst 0.5 cm below hepatic bifurcation. We then performed a roux-en-Y hepaticojejunostomy. The postoperative course was uneventful, and the patient was discharged on postoperative day 4.
V254

A Case of Gallbladder Volvulus with Classic Imaging Finds and Intraoperative Demonstration of Torsion

Benjamin Ferrel; Marc Gorvet; Ryan Roe; MercyOne Medical Center.

Gallbladder volvulus is a rare, acute surgical condition that can be difficult to diagnose preoperatively. We present a case of gallbladder volvulus which displayed several key imaging findings. Intraoperative video is presented demonstrating the torsion. A brief review of gallbladder volvulus is presented, and classical imaging findings described in the literature are reviewed.

V256

A Rare Case of a Right-Sided Bochdalek Hernia Containing a Large Lipoma

Mallory Jebbia, MD; Brian Lugo, MD; Huntington Hospital.

Bochdalek hernias offer a challenging surgical dilemma: chest or abdomen? Bochdalek hernias approached transabdominally are often amenable to minimally invasive repair. However, this works best for left-sided hernias in which the left diaphragm is far more accessible. For right-sided Bochdalek hernias, the location of the liver warrants a transthoracic surgical approach. Due to technical challenges securing the mesh to the lateral chest wall, thoracotomies have been the mainstay for right-sided Bochdalek hernia repair. This case report presents a new technique for affixing mesh to the lateral chest wall for a minimally invasive transthoracic repair of a right-sided Bochdalek hernia.

V255

Laparoscopic Release of Median Arcuate Ligament

Huy D Hoang, MD; Douglas Greer, MD; Alexa Roth, MD; Amrita Klar, MD; Pearl Ma, MD; Keith Boone, MD; Kelvin Higa, MD; Advanced Laparoscopic Surgical Associates.

We present a case of a 63 year-old woman who developed median arcuate ligament syndrome (MALS) a few years after laparoscopic Roux-en-Y gastric bypass. Symptoms included postprandial epigastric pain, nausea, and vomiting. Initial workup and treatment included cholecystectomy, upper endoscopy, and endoscopic retrograde cholangiopancreatography. However, her symptoms persisted. During the course of her workup, magnetic resonance imaging was obtained suggesting MALS. The diagnosis was confirmed on angiography which showed severe compression of the celiac artery on expiratory phase. She underwent laparoscopic MAL release with resolution of symptoms. However, symptoms recurred after 2 years which prompted another laparoscopic MAL release.

V257

Successful Laparoscopic Repair of an incarcerated Bochdalek Hernia with Mesentero-Axial Gastric Volvulus in a 54 Years Old Lady

Qin Yi Lee; Saleem Ahmed Abdul Kareem; Danson Xue Wei Yeo; Kaushal Amitbhai Sanghvi; Tan Tock Seng Hospital.

Gastric Volvulus is rare. It has a high mortality rate of up to 60% when gastric ischemia sets in. Unfortunately, most patients present with non-specific symptoms hence it is a diagnostic challenge. We report a case of a gastric outlet obstruction from an incarcerated bochdalek hernia with mesenteroaxial gastric volvulus in an adult which was successfully managed laparoscopically.
Laparoscopic Repair of Neuromuscular and Vascular Hamartoma of Ilium Causing Intermittent Bowel Obstruction

Elena Labovitis1; Nisha Narula2; Lisa Shimotake2; Karen Gibbs2; Indraneil Mukherjee2;1Touro College of Osteopathic Medicine; 2Staten Island University Hospital.

A 44-year-old lady presented with episodic abdominal pain, vomiting and diarrhea for over 10 years. Previously she had been worked up with multiple diagnostic tests which showed dilated small bowel loops, strictures and interloop fluids. Diagnostic laparoscopy showed thickened small bowel and proximal dilation. Pathology showed a circumscribed area of narrowing with ulcerations, disorganized muscularis mucosa and submucosa, metaplasia in the distal end, and gastric heterotopia at the proximal end. These findings are consistent with a so-called neuromuscular and vascular hamartoma of the small bowel. Post operatively the patient had an uneventful recovery, and she continues to live asymptptomatically.

Laparoscopic Repair of Incarcerated Diaphragmatic Hernia Through Relaxing Incision After Previous Dor Fundoplication

Luis Pina, MD; Brian Dessify, DO; David Parker, MD; Mustapha Daouadi, MD; Geisinger Health System.

This is a case presentation of a laparoscopic repair of incarcerated diaphragmatic hernia secondary to a relaxing incision performed for a prior paraesophageal hernia repaired with Dor Fundoplication. The patient is a sixty-three year old female presenting with six days of abdominal pain, nausea, and vomiting. We performed a laparoscopic repair of a right diaphragmatic hernia containing right colon and omentum, with gore-tex mesh sutured circumferentially to the diaphragm. Crural relaxing incisions are an important technique to avoid tension on crural closures and mesh bridges across the hiatus. It is safe to reinforce relaxing incisions with synthetic mesh.

The Bougie Went Easy, But Oops!

Jasmin Rahesh, MBA, MS; Ellen Wilson; Muhammad Nazim, MD; Hassan Ahmed, MD; Texas Tech University Health Sciences Center School of Medicine.

OBJECTIVE: To describe rare complication and management of esophageal mucosal rupture after Bougie insertion.

METHODS: 76 year old woman with symptomatic paraesophageal hernia repair. After favorable preoperative workup, underwent Robotic PEH repair with Nissen-Hill hybrid repair. A 58-French bougie was used intraoperatively to configure fundoplication. Upper-endoscopy revealed longitudinal 7–8 cm esophageal mucosal tear, that was repaired with endoscopic clips. As a precaution, bilateral chest tubes, venting gastrostomy and feeding jejunostomy were placed.

RESULTS: Upper GI-fluoroscopy revealed no leak. Uneventful postoperative course discharged on full liquid diet. Tubes were removed in clinic 8 weeks later.

CONCLUSION: Endoscopic management can be effective.

Robotic Drainage of a Recurrent Abdominal Abscess from DROPPED GALLSTONES

Indraneil Mukherjee1; Harpreet Kaur2; Adeel Shamim1; Nisha Narula1; Lisa Shimotake1; Karen Gibbs1; 1Staten Island University Hospital; 2Bronx Lebanon Hospital.

64 year old gentleman with a past medical history of HIV, CAD, DM, and HTN presents Gangrenous Cholecystitis. He underwent an emergent cholecystectomy and was discharged. 6 months later he presented with an abdominal abscess in the right upper quadrant midway between his umbilicus and subcostal plane. His symptoms resolved with Image-guided Aspiration and Antibiotics. Another 5 months later he presented with a similar abscess and after drainage, he was taken for Robotic drainage of Abdominal abscess which showed a dropped gallstone. After removal of the foreign body and adequate drainage, he has remained asymptomatic.
An Open and Shut Case: Single-Anastomosis Duodenal Switch after Open Cholecystectomy

Poppy Addison, MD; Mitchell Roslin, MD; Lenox Hill Hospital.

While prior open RUQ surgery can be considered a relative contraindication to complex laparoscopic bariatric surgery, we present our technique for a single-anastomosis duodenal switch in a young woman with refractory morbid obesity and hypertension with a prior open cholecystectomy in a brief video. The patient recovered well and has not had postoperative complications within the first few months to date.

Laparoscopic Sleeve Gastrectomy in Situs Inversus Totalis

Loic S Tchokouani, MD; Manish Parikh, MD; Patricia Chui, MD; NYU Langone/Bellevue Hospital Center.

This is a 35 year old female with history of Stage 2 breast cancer, BRCA1 + status post bilateral total mastectomy and chemotherapy with a BMI of 45 presenting for bariatric surgery evaluation to qualify for reconstructive surgery. She underwent proper pre-operative bariatric clearance and was found to have situs inversus totalis on preoperative imaging. She underwent uneventful Laparoscopic Sleeve Gastrectomy with laparoscopic ports placed mirror image in the abdomen. The post-operative course was uneventful. This case further supports previous conclusions that Laparoscopic sleeve gastrectomy is safe and feasible in situs inversus totalis.

Laparoscopic Conversion of Single Anastomosis Duodenal Switch to Roux-En-Y Gastric Bypass and Recurrent Hiatal Hernia Repair.

Jeffrey Lipman, MD; Randal Zhou, MD; Timothy Farrell, MD; University of North Carolina.

Our video demonstrates a technique for conversion of a single anastomosis duodenal switch to roux-en-y gastric bypass and repair of a recurrent hiatal hernia in a patient with severe postoperative gastroesophageal reflux disease. As the single anastomosis duodenal switch has a reflux potential similar to sleeve gastrectomy, we have been seeing a series of patients referred to our institution for revision. After excluding obstruction at the duodenouloestomy or distally that could be driving reflux, we elect to simply create a gastric pouch out of the proximal sleeved stomach, while leaving the distal stomach and the loop duodenouloestomy in situ.

Laparoscopic Assisted Robotic Radical Prostatectomy With Pelvic Lymph Node Dissection Using Viable Cryopreserved Umbilical Tissue to Improve Cavernosal Nerve Function

Joshua Volin, BS; Brett Watson, MD; Lior Kopel, BS; Samantha Kraemer, MD; Jason Hafron, MD; Oakland University William Beaumont School of Medicine; Beaumont Hospital.

Radical prostatectomy is the preferred treatment for patients with clinically localized prostate cancer and is typically performed using a robotic approach. Surgical techniques that preserve the neurovascular bundle minimize the risk of incontinence and erectile dysfunction post-operatively. Umbilical cord tissue is a relatively new technique, which has been shown to reduce inflammation and promote regenerative healing. In this video we show a robotic radical prostatectomy with bilateral nerve sparing technique utilizing a cryopreserved umbilical cord allograft nerve wrap.
V266

The Unclosable Hiatus: Laparoscopic Repair of Giant Hiatal Hernia With a right Crural Relaxing Incision
Juan P Toro, MD, FACS, SAGES1; Manuel Arrieta G, MD2; Jose E. Agamez, MD1; Rene M. Escobar, MD1; Carlos H. Morales, MD1; 1Universidad de Antioquia; 2Universidad de la Sabana.

Repair of a giant paraesophageal hernia is a challenge for the surgeon, especially without tension. One way to accomplish a tension-free repair is to use a relaxing incision. We present a 67-year-old man with a giant hiatal hernia and mesentero-axial gastric volvulus, that underwent a successful laparoscopic hernia repair using a relaxing incision on the right diaphragm and a fixation of the stomach with a tube gastrostomy. There were no complications registered during or after procedure. In the follow-up at 9 months there is no evidence of recurrence and the patient denied symptoms of GERD or dysphagia.

V267

Laparoscopic Repair of a Posterior Flank Hernia after Lumbar Spinal Fusion
Ton Wang; Oliver Varban, MD; University of Michigan.

We present a case of a rare complication after lateral lumbar interbody fusion through a retroperitoneal approach. Although the posterior approach provides access to the lumbar spine without a transabdominal incision, the psoas fascia merges with the transversalis fascia laterally, and the thoracolumbar fascia attaches to the inferior border of the twelfth rib, resulting in potential hernia formation. Our patient developed a posterior subcostal abdominal wall hernia 10 months after spinal surgery. We performed a laparoscopic repair of the hernia with placement of coated polyester mesh. The patient recovered well without any evidence of recurrence in the early postoperative period.

V268

Robotic Revision of Nissen Fundoplication
Patrick Dolan, MD; Victoria Aveson, MD; James Senturk, MD; Cheguevara Afaneh, MD, FACS; Omar Bellorin, MD, FACS; NYP-Weill Cornell Medical College.

Introduction: Reoperative foregut surgery is technically challenging. The enhanced visualization and articulating instruments provided by robotic surgery aid in these difficult cases.

Case: Peritoneal access was obtained and robotic trocars placed. The crura were dissected free from all adhesions, exposing a recurrent hiatal hernia. A penrose was passed in the retroesophageal space for caudal retraction of the stomach. The esophagus was circumferentially dissected to obtain 4 cm of intra-abdominal esophageal length. The crura were closed and reinforced with a bioabsorbable mesh. The prior wrap was then refashioned. Intraoperative endoscopy confirmed no leak and an intact wrap around the gastroesophageal junction.

V269

A Right Posterior Diaphragmatic Hernia in an Elder Patient
Bernardo Fernandez Rodarte, MD; Jorge Pablo Perez Macias, MD; Angel Martinez Vela, MD; Gerardo Saldaña Lozano, MD; Mariana Salcido Baeza, MD; Danilo Tuene De La Peña, MD; Antonio Morales Cardona, MD; Christus Muguerza Alta Especialidad.

Acquired diaphragmatic hernias after thoracic surgery are uncommon. We report a case of an 83-year-old woman with a history of pleural decortication 20 years ago. She arrived at ER with new onset of severe dyspnea and epigastric pain. Thoraco-abdominal computed tomography showed a dilated ascending colon and the presence of a 5 cm width right diaphragmatic hernia. The patient was submitted to surgery and a laparoscopic herniorrhaphy was done. The postoperative recovery was uneventful. We concluded that the management of this rare complication could be achieved with a laparoscopic repair without the use of mesh with acceptable postoperative results.
V270

Laparoscopic Right Adrenalectomy for 11-cm Functional Adrenal Oncocytoma
Shawn Liechty, MD; Ian Schlieder, DO; Alexander Ostapenko, MD; Daniel Kleiner, MD, FACS; Danbury Hospital; University of Utah.

A 36-year-old male presented with right lower back pain, found to be a right adrenal mass. Workup demonstrated an 11-cm right adrenal mass with displacement of right kidney and renal vein. Functional evaluation demonstrated subclinical Cushing syndrome by dexamethasone suppression test. The patient went to the operating room for laparoscopic right adrenalectomy. The tumor was successfully resected with R0 margins. The patient recovered quickly and was discharged on post-operative day 2. He remains alive and well.

V272

Gallstone Abscess: Evidence for a Clinical Syndrome
Shawn Liechty, MD; Alexander Ostapenko, MD; Daniel Kleiner, MD, FACS; Danbury Hospital.

Dropped gallstones, in rare circumstances, can cause complications such as abscess or fistula. Patients present with a variety of clinical and radiographic signs that can be described as a syndrome. In this study, we identify the features of gallstone abscesses. Additionally, we describe our operative approach and tips for laparoscopic abscess washout and gallstone retrieval. Interestingly, all retained gallstones were pigmented, and all but 1 patient had choledocholithiasis treated with ERCP. These findings may allude to previously unknown risk factors for this unusual complication. Also, operating room cultures grew diverse and resistant species, which may also contribute to gallstone abscess.

V271

Laparoscopic Transabdominal Retromuscular (TARM) Repair for Bilateral Irreducible Ventral Hernia - a Novel approach for Irreducible Ventral Hernia
Sulay K Shah, Dr; Anshumi Desai, Dr; Sameer A Rege, Dr; KEM Hospital and Seth GS Medical College Mumbai India.

Laparoscopic Transabdominal retromuscular (TARM) repair is a novel approach towards ventral hernia. We present a case with specific utility of TARM in irreducible hernia, with combined advantage of low cost retromuscular mesh and visualisation of transabdominal plane, also aiding in examining hernia contents. TARM can also be added with a Posterior component separation like Transversus abdominis release (TAR) to provide better dissection of sublay space and adequate coverage. With a TARM-TAR approach the mesh is completely retromuscular – retrorectus with retrotransversus. The main advantage of technique is Low Cost of the mesh, Larger dissection space, and assessing the viability of hernia contents.

V273

Laparoscopic Revision of a Roux-en-Y Gastric Bypass Jejunal-Jejunal Anastomosis
Elaine Carelus, MD; Emily Watters, MD; Erin Moran-Atkin, MD; Diego Camacho, MD; Montefiore Medical Center.

In this video we describe a laparoscopic revision of a Roux-en-Y gastric bypass (RYGB) jejunal-jejunal (JJ) anastomosis for management of an acute hemorrhage and anastomotic leak at the JJ anastomosis. The patient underwent an uncomplicated RYGB. However post-operatively developed tachycardia, gastrointestinal bleeding and imaging findings of a small bowel obstruction and intramural JJ hematoma. Intraoperatively we discovered a dehiscence of the JJ staple line. We performed a revision of by excision of the entire prior anastomosis and creation of two small new bowel anastomoses; bili-pancreatic to common channel, and roux limb to common channel.
V274

Robotic Disc Excision for Colorectal Endometriosis

Mayou Martin M Tampou, Dr; Salini Hota; Salvatore Parascandola; Michael L Horsey; Gaby Moawad; Vincent Obias; The George Washington University; Eastern Virginia Medical School; Walter Reed National Military Medical Center.

Endometriosis is characterized by the presence of endometrial stroma outside the uterus and affects the colon and rectum in 5–37% of cases. For deeply infiltrating or symptomatic endometriosis of the colon and rectum, surgical resection is the recommended treatment. Three surgical techniques have been described in literature and include the shaving technique with or without oversewing, disc excision, and segmental resection with anastomosis. This video demonstrates the major steps in the surgery of endometriosis utilizing a robotic approach including sigmoid mobilization, adhesiolysis of the ureters, establishment of the rectovaginal plane, and disc excision using a circular stapler.

V276

Robotic Gastro-Gastric Fistula En Bloc Resection After RYGB

Jean F Salem, MD; Abdulaziz A Arishi, MD; Maher El Chaar, MD, FACS; St. Luke's University Health Network.

This video demonstrates a robotic gastro-gastric fistula en-bloc resection in a patient with a history of RYGB. The patient failed endoscopic closure twice, using padlock clips and overstitch device. First, the adhesions are taken down then the Roux limb is dissected off the gastric remnant and transected distal to the gastro-jejunal anastomosis. The short gastric vessels are divided and the gastric remnant is transected at the level of the antrum. The gastric pouch is then transected proximal to the gastro-jejunalostomy and the specimen is removed en-bloc. The video shows the anatomy and dissection facilitated with the use of the robot.

V275

Laparoscopic Extended Total Mesorectal Excision for Bulky Rectal Carcinoma—A Video Vignette

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Objectives: To demonstrate systematic approach for performing laparoscopic extended TME for bulky rectal cancer.

Methods: A 34 years old gentleman with bulky rectal cancer. He received neoadjuvant chemoradiation (NACTRT) followed by 4 more cycles of chemotherapy with reassessment MRI suggestive of involvement of right seminal vesicle. This patient underwent laparoscopic abdomino-perineal resection with enbloc bilateral seminal vesicle excision.

Results: The surgery was uneventful with an uneventful recovery.

Conclusions: Laparoscopic extended TME resections can be safely and effectively performed for bulky rectal cancers.

V277

Laparoscopic Resection of Retroperitoneal Schwannoma

Amir Szold, MD 1; Ludovica Baldari, MD 2; Assia Medical, Assuta Hospital; Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico di Milano.

This video shows the laparoscopic resection of a retroperitoneal schwannoma next to the left side of the aorta and posterior to left renal vein. The patient was placed in 90 degrees right lateral position. The section of phrenicocolic and phrenicosplenic ligaments allows spleen and left colonic flexure mobilization. The perirenal fat is dissected and left kidney is completely mobilized and reflected medially, allowing identification of the mass. The muscular plane is split anterior to the tumor, allowing its dissection. Subsequently, the diaphragmatic muscular plane is closed using a running barbed suture. The specimen is removed with endobag through a mini-laparotomy.
Zooming Inside Narrow Funnel Technique For Difficult Laparoscopic Cholecystectomy.

Samer S Zino, MD, MRes, PhD, FRCS; Ninewells Hospital and Medical School / Dundee.

This video presents a technique to dissect difficult oedematous hepatocystic triangle in a safe way, that keep important structure away.

Zooming inside narrow funnel (ZINF) technique; starts with circular marking of the peritoneum 1–3 cm high on Hartmann’s pouch. This marking will be deepened until reaching the gallbladder mucosa. Then the dissection is carried out in the submucosal plane toward the Gallbladder neck, until the cystic duct is identified. Cholangiogram could be performed to exclude cystic duct stone and assess biliary tree.

Apply ZINF technique the only important structure encountered would be cystic duct, cystic vessels and its submucosal branches.

Laparoscopic Repair of a Giant Marginal Ulcer Perforation After Roux-en-Y Gastric Bypass

David A Grubb, MD; Bestoun H Ahmed, MD, FACS, FASMBS, ABOM; UPMC.

We present a patient who underwent laparoscopic repair of a giant marginal ulcer perforation after Roux-en-Y gastric bypass. The patient had a remote history of a gastric bypass with a retrocolic, retrogastric Roux limb placement which made the case more challenging. We also performed laparoscopic drainage of multiple intra-abdominal abscesses. We demonstrate the feasibility of a minimally invasive technique despite the complexity of a delayed presentation in addition to difficult anatomy.

Modified Roux-en-Y Gastric Bypass in Rats: A Technically Feasible, Single-Surgeon Protocol

Jerry T Dang, MD; Valentin Mocanu, MD; Breanna Fang, BSc; Michael Laffin, MD, PhD; Shahzeer Karmali, MD, MPH; Karen Madsen, PhD; Daniel W Birch, MD, MSc; University of Alberta.

In this video, we present the techniques for a modified Roux-en-Y gastric bypass (RYGB) procedure in rats that result in a small gastric pouch using surgical staplers. This technique removes the forestomach which results in a small gastric pouch much like that following typical human RYGB. Surgical stapling results in better hemostasis than sharp division. Weight loss and metabolic change was significant compared to the sham cohort with an excellent survival of 88.9%. Notably, this procedure can be performed by a single surgeon. Once mastered, this procedure will provide a reproducible tool for studying the mechanisms and effects of RYGB.

Laparoscopic Appearance of Mesenteric Lymphangioma

Marc Gorvet, DO; Jan Franko, MD, PhD; MercyOne Des Moines Medical Center.

Mesenteric lymphangioma is a rare diagnosis predominantly occurring in children (90% of cases) with a male–female ratio of 1.5–3:1. A 73-year-old male presented with slowly worsening right-sided abdominal discomfort and bloating. CT demonstrated a 4 cm hypodense mass of the small bowel mesentery. Image-guided biopsy was deemed unsafe due to proximity to vasculature. The video demonstrates typical appearance of this rare entity, nearly pathognomonic, during diagnostic laparoscopy. Pathology showed a benign cystic lesion with mild chronic inflammation, favoring lymphangioma. Key points: classical surgical appearance combined with release of lymph, growing, symptomatic lesions may prove to be benign or malignant.
V282

Laparoscopic Extended Total Mesorectal Excision with en-bloc Right Seminal Vesicle Excision in Locally Advanced Rectal Cancer

Tushar Pawar; Ashish Pokharkar; Rahul Chavan; Diwakar Pandey; Jitender Rohila; Ashwin deSouza; Avanish Saklani; Tata Memorial Hospital, Mumbai, India.

Surgical technique of laparoscopic Extended Total Mesorectal excision with en-bloc right Seminal vesicle excision. With better imaging and exact staging, and advanced radiation therapy techniques now it is possible to use laparoscopic surgery in more advanced rectal cancers. Another factor for success is the volume of cases. Tata Memorial Hospital is a high-volume tertiary care cancer center in India. Here we present a case with extended resection performed laparoscopically in locally advanced rectal cancer. With the judicious use of laparoscopy in selected cases, surgical outcomes in such cases can be optimized.

V284

Repair of Recurrent Hiatal Hernia After Distant Gastric Bypass

Benjamin Clapp, MD; Alexa Jauregui, BS; Andres Vivar, BS; 1Texas Tech HSC Paul Foster School of Medicine; 2Universidad Autonoma de Guadalajara.

This video highlights the technical aspects of repairing a recurrent hiatal hernia after a gastric bypass. The first hiatal hernia repair was with a bioabsorbable mesh. This was performed with PHB4 mesh 16 years after the original laparoscopic Roux-en-Y gastric bypass. This subsequently recurred 14 months later and the patient was taken back to the operating room. The PHB4 mesh is clearly present at 14 month. Highlights of the video include a late look at a “bioabsorbable mesh” and operative techniques for reoperative foregut surgery.

V283

Diagnostic Laparoscopy with Retrieval of BB Gun Bullet

Taha R Mallick, MD; Arjun Chandrasekar, MD; David A Benalcazar, MD; Federico L Gattorno, MD, FACS, FICS; Woodhull Medical Center.

Minimally invasive surgery is finding an increasing role in trauma patients, a field which has traditionally been dominated by open surgery. We present a case of a 19 year old male patient who sustained a gunshot wound to his abdomen with a BB gun and was successfully managed with diagnostic laparoscopy and retrieval of the BB gun bullet. Post-operatively, our patient made an uneventful recovery and was discharged home on post-operative day 3. We hope this case highlights the role of minimally invasive surgery for management of trauma, particularly in hemodynamically stable patients with limited injury to intra-abdominal structures.

V285

Jejunojejunostomy Anastomotic Revision After Braun Enterenterostomy

Thomas Q Xu, MD; Marc Sarran, MD; John Lewandowski, MD; Scott Schimpke, MD; Benjamin Veenstra, MD; Rush University Medical Center.

We present a case report of a patient who underwent jejunojejunostomy revision for a chronic, intermittent bowel obstruction after undergoing a Braun enterenterostomy to relieve an early obstruction after roux-en-Y gastric bypass. Preoperative imaging and upper endoscopy was unable to identify the source of the patient’s chronic abdominal pain. Due to persistent symptoms, he underwent diagnostic laparoscopy which demonstrated torsion at the prior jejunojejunostomy. This bowel segment was resected and intestinal continuity was restored with creation of a new roux and hilo-pancreatic limb. His abdominal pain resolved postoperatively and he continues to tolerate a general diet.
Robotic Transanal Endoluminal Surgery (ELS): Use of a New Platform for the Excision of Rectal and Distal Colon Lesions

Lance Horner, MD; Gabriela Doyle, MD; Ovunc Bardakcioglu, MD; University of Nevada Las Vegas School of Medicine, Department of Surgery.

Local management of lesions of the colon and rectum is currently limited to traditional endoscopic or transanal (including robotic) approaches. Here, we describe the use of a new endoluminal surgery (ELS) platform which is currently under investigation in a multi-center clinical trial in the United States. We demonstrate in this video how this new system's jointed (elbow and wristed) instruments with 7 degrees of freedom, can be used to easily navigate the rectum and distal colon to resect lesions. This may provide the ability to overcome limitations of currently available technology.

Robotic Assisted Giant Epiphrenic Esophageal Diverticulectomy with Myotomy

Anna K Gergen, MD; Akshay Pratap, MD; University of Colorado.

Epiphrenic esophageal diverticula (EED) are rare. The estimated incidence is about 1-500,000/year. EED usually result from a combination of esophageal obstruction, functional or mechanical and a point of weakness of the muscularis propria. Most of the symptoms are unspecific, but dysphagia is most common. Chest radiograph, barium esophagogram, endoscopy and manometry are diagnostic tools. The treatment methods are conservative medical therapy, myotomy, diverticulectomy and fundoplication. We present a case with a long history of symptoms which caused by epiphrenic diverticulum surgically corrected with robotic approach and highlight tips and tricks for a successful outcome.

Laparoscopic Double Mesh Repair of a Large Morgagni Hernia

Corrado Pedrazzani, MD, Professor; Matteo Rivelli, MD; Giulia Turri, MD; Cristian Conti; Alessandro Valdegamberi; Alfredo Guglielmi, MD, Professor; Department of Surgical Sciences, Dentistry, Gynecology and Pediatrics, Unit of General and Hepatobiliary Surgery, University of Verona, Verona, Italy.

Morgagni hernia accounts for less than 2% of congenital diaphragmatic defects surgically repaired in the adulthood. Surgery is advised due to the risk of life-threatening complications such as volvulus or bowel strangulation. Several technical issues such as the use of prosthetic mesh and the need for reduction of the hernia sac are still debated. Recently minimally invasive approach has been proved to improve surgical outcomes. We present a video with technical report of a large MH in a 58 years old male treated with laparoscopic repair without resection of the hernia sac and with the use of a double mesh.

Robotic Pancreaticoduodenectomy with Cholecystectomy

Sharona Ross, MD, FACS; Gabriel Rivera-Espineira, MD; Timothy Bourdeau, BS; Iswanto Sucandy, MD, FACS; Alexander Rosemurgy, MD, FACS; AdventHealth Tampa.

This video is of a robotic pancreaticoduodenectomy with cholecystectomy undertaken in a 72-year-old lady. CT scan demonstrated a 4.8 cm pancreatic head mass. The Kocher maneuver is first undertaken, and the jejunum is divided. Then the duodenum distal to the pylorus is stapled. The pancreas is then divided and freed off the portal vein. A cholecystectomy is then preformed. The a 1-layer hepaticojejunostomy is constructed. Following that a 2-layer pancreatojejunostomy is constructed followed by a gastrojejunostomy. A JP drain is then placed. The patient tolerated this operation well. Pathology demonstrated a moderately differentiated adenocarcinoma. She was discharged on POD 3.
**V290**

**Xiong’s Three Step Maneuver for Superior Mesenteric Vein Exposure and Central Vascular Division in the Caudal-To-Cranial Approach Laparoscopic Right Hemicolectomy**

Xiong Wenjun, PhD; Wang Wei, PhD; Zhu Xiaofeng, PhD; Guangdong Provincial Hospital of Chinese Medicine / The 2nd Clinical College of Guangzhou University of Chinese Medicine.

First step is identifying and cutting the conjunction between the right mesocolon and small intestinal mesentery. The medial boundary is marked along the SMV. Second step is the mesocolon along the SMV are dissected using a caudal-to-cranial approach with ileocolic vein, Henle’s trunk and pancreas exposed. Third step is central vascular division of the ileocolic vessels, right colic vessels, the colic branches of Henle’s trunk and middle colic vessels with lymph nodes dissection.

**V291**

**Robotic Median Arcuate Ligament Release in a Hostile Abdomen**

Arturo E Estrada, MD; Cosman Camilo Mandujano, MD; Flavio Malcher, MD; Montefiore Medical Center.

This is a video presentation of a robotic-assisted median arcuate ligament release in a hostile abdomen (two prior laparotomies). Focusing our attention at the 6 min mark, 4x speed video, we highlighted the advantages of the robotic approach for adhesiolysis and intra-op complication management. Isolation of the common hepatic and left gastric arteries for traction, right crura split for aortic exposure and mobilization of the enlarged caudate lobe are shown. Extensive dissection and excision of peri celiac tissue is executed as it is hypothesized to cause these symptoms.

**V292**

**Management of Metastatic Cecal Neuroendocrine Tumor**

Joshua K Phillips, MD; Jason Zimmermann, MD; Hooman Khabiri, MD; Fred Brody, MD; James Duncan, MD; Washington DC Veterans Affairs Medical Center

This case illustrates a 31-year-old male with a 3-cm carcinoid tumor at the ileocecal valve. Preoperative staging included a DOTATATE scan which revealed intense uptake at the site of the mass and lateral to the IVC concerning for lymphatic spread as well as a focus of uptake in the right hepatic lobe consistent with metastatic disease. This video depicts a robotic right hemicolectomy followed by transarterial chemoembolization of the single liver lesion and subsequent microwave ablation. This case illustrates the evaluation, workup, and combined surgical and interventional radiologic management of a cecal neuroendocrine tumor metastatic to the liver.

**V293**

**Laparoscopic Cholecystectomy with ICG Cholangiography and Removal of Cholecystostomy Tube**

George Tadros, MD; Bakhtawar Mushtaq, MD; Sinal Patel, MD; Francisco X Azar, MD; Emanuele Lo Menzo, MD, PhD, FACS, FASMBS; Samuel Szomstein, MD, FACS, FASMBS; Raul J Rosenthal, MD, FACS, FASMBS; Cleveland Clinic Florida.

Intraoperative cholangiography with indocyanine green (ICG) aids to identify biliary structures. This is a case of a 64 year old male with delayed presentation of acute cholecystitis and prior placement of a cholecystostomy tube. 2.5 mg of ICG was injected one hour prior to laparoscopic cholecystectomy. Dissection started laterally then proceeded at the level of the gallbladder’s infundibulum. Cystic duct and artery were visualized with creation of a window between the two. The gallbladder was taken off the liver bed using the electro-cautery hook. Cystic artery and ducts were clipped and divided. The patient made an uneventful recovery.
Completion Appendectomy in a Patient with Acute on Chronic Recurrent Appendicitis Status Post Incomplete Appendectomy

Zachary N Weitzner, MD; Lina Hu, MD; Tara Russell, MD; Erik P Dutson, MD; University of California, Los Angeles.

We present a case of laparoscopic completion appendectomy in a patient who had previously undergone subtotal appendectomy for appendicitis. This case emphasizes the importance of complete appendectomy whenever possible, even in when the appendix appears obliterated. Though often thought to resolve when severely destroyed, a retained appendix can result in chronic intraabdominal infection. This chronic infection in post-appendectomy patients results in significant scar tissue, difficulty identifying tissue planes, and significant risk of damage to the ureters and bowel. Thus, we present a case demonstrating the difficult dissection required to safely remove a chronically inflamed appendiceal remnant.

SAFE LAPAROSCOPIC JEJUNOSTOMY.

Hollie A Clements, MBChB, MRCS; Samer Zino, FRCS; Pradeep V Patil, MD, FRCS; Ninewells Hospital & Medical School.

We demonstrate the laparoscopic formation of a feeding jejunostomy. The steps outlined are an exact replication of the steps we use in our open technique but with the added benefit of easy identification of the DJ flexure and a safe segment of jejunum laparoscopically. The steps are:

1. Identification of the DJ flexure.
2. Fixation of suitable segment of jejunum to left lateral abdominal wall
3. Purse-string suture 2-3 cm from fixation point with enterotomy at centre
4. Jejunostomy tube inserted & balloon inflated
5. 3-point fixation
6. Final fixation suture 1-2 cm distal to jejunostomy site.

Laparoscopic Treatment of Mirizzi Syndrome with Cholecystogastric and Cholecystocholedochal Fistula

John H Frankel, MD; Akshay Pratap, MD; University of Colorado.

Mirizzi syndrome is an uncommon complication of longstanding gallstone disease resulting in obstructive jaundice and remains surgically challenging. Mirizzi syndrome is generally considered a contraindication to laparoscopic surgery. We present the surgical experience of a patient with a rare sequela of Mirizzi syndrome with a cholecystogastric and cholecystocholedochal fistula diagnosed correctly preoperatively and treated laparoscopically.

I Can See Clearly Now: A Novel In Vivo Laparoscopic Cleaning Device

John Uecker, MD, FACS1; Silvana Nasreddine1; Christopher Idelson, PhD1; Christopher Pearcy, MD2; Carter Rohling, MD3; Michael Truitt, MD2; 1University of Texas at Austin Dell Medical School; 2Methodist Health System Dallas.

Minimally invasive surgical techniques are commonly employed in every subspecialty. Poor visualization due to fogging and soilage remain a challenge. This leads to decreased efficiency, surgeon frustration, and longer operative times. Poor or complete loss of visualization during a cleaning event exposes the patient to increased risk. We submit our experience with an in vivo laparoscopic cleaning device. Camera removal was avoided in 92% of 246 separate soilage events, with an average of 1.9 swipes, and no adverse events. To our knowledge, this is the first FDA approved en vivo laparoscopic cleaning device.
Robotic Assisted Left Colectomy with Suprapubic Ports

Melody Lin, MD; Salomone DiSaverio, MD; Rahila Essani, MD, FACS; 1Baylor Scott and White Health; 2University of Insubria, Varese.

Robotic assisted colectomies with the use of all suprapubic incisions can offer patients the benefits of excellent cosmesis, shortened length of stay, and satisfactory oncological outcome. We present a 55-year-old female with Stage IIA (pT3N0) colonic adenocarcinoma who presented with a splenic flexure mass on screening colonoscopy. We performed a robotic assisted left colectomy. Four 8 mm ports were used, with one port first upsized to 10 mm to accommodate the robotic stapler and then to 30 mm to extract the specimen. Final pathology demonstrated Stage IIA (pT3N0) adenocarcinoma, with zero of forty harvested lymph nodes demonstrating metastasis. All margins were negative.

Recurrent Type IV Hiatal Hernia Repair after Esophagectomy with Gastric Conduit

Gary Grinberg, MD; Vaughn E Nossaman, MD; Brian Rezvani, MD; Pandu Yenumula, MD; Kaiser Permanente South Sacramento.

Mr. Doe is a 74 year old male status post esophagectomy with gastric conduit in 2018. He subsequently completed chemotherapy. Post-operatively he developed a type IV hiatal hernia that required urgent intervention at which time the herniated contents were reduced and a gastropexy performed to narrow the hiatus. He now presents 6 months later with a recurrent type IV hiatal hernia with nausea, vomiting, and inability to tolerate oral nutrition. With normal vital signs, but CT imaging consistent with herniation of his small and large intestine, he is taken emergently to the operating room for hiatal hernia repair.

The Aborted Cholecystectomy: Back to Basics and Setting Up For Success

Paul Anthony R Del Prado, MD, FACS; Valleywise Health Medical Center.

Common bile duct injury occurs in up to 0.5% during laparoscopic cholecystectomy. The critical view of safety has been advocated to decrease this risk. Occasionally, procedures are aborted to avoid this devastating injury and cholecystostomy tubes utilized in order to manage cholecystitis. However, recurrent cholecystitis occurs in up to 18% of patients after drainage. We present a case of a patient with complex surgical history of liver trauma and an aborted open cholecystectomy, who has been managed with percutaneous cholecystostomy for recurrent cholecystitis. The video discusses a systematic approach in dealing with a very difficult gallbladder laparoscopically.

A Rare Presentation of a Gastrointestinal Schwannoma with Bulky Lymphadenopathy—Operative Management Using a Combined Laparoscopic/Endoscopic Approach

Gregory Bach, MD; Cannon Nelson, MD; Joseph Sujka, MD; Chris G DuCoin; University of South Florida.

56-year-old female evaluated for a gastric mass. Preoperative work-up included MRI and endoscopic ultrasound with tissue biopsy. MRI revealed some slightly enlarged lymph nodes in the gastrohepatic ligament. EUS and biopsy determined the mass was a 4.5 cm gastric schwannoma. Therapeutic options, were discussed with the patient at which time she consented for “Robotic-assisted Laparoscopic Partial Gastrectomy, Gastric Lymph Node Resection—D1 Lymphatic Resection, and Intraoperative Upper Endoscopy”. The patient did well post operatively and was advanced to a diet over the course of her hospital stay. Final pathology confirmed gastric schwannoma and all lymph nodes were negative for malignancy.
V303

Laparoscopic Repair of a Combined Incisional and Spigelian Hernia
Ramses A Saavedra, MD; Edward Auyang, MD, MS, FACS; University of New Mexico School of Medicine

Abdominal hernias may present in a variety of locations and from multiple etiologies. Here we show the surgical management of the unusual combination of an incisional hernia and adjacent Spigelian hernia. The patient is a 53-year-old female who previously underwent a colpexy through a Pfannenstiel incision. She presented with multiple episode of intermittent small bowel obstruction. A CT scan showed bowel within the incisional hernia for which she was taken for a laparoscopic hernia repair. This video displays the technique used for the repair.

V304

Robotic Incidental Resection of Round Ligament Lipoleiomyoma During Inguinal Hernia Repair
Katrina M Pardo; Filipe Kunzler de Oliveira Maia, MD; Anthony M Gonzalez, MD, FACS, FASMBS; Baptist Health South Florida

A 74-year-old female presented with palpable moderate to large bilateral inguinal hernias. No imaging was needed preoperatively since hernias were palpable on examination. During the robotic preperitoneal inguinal hernia repair, a mass was noted on the peritoneal surface along the right round ligament. The mass was resected after the hernia repairs. Post operatively, pathology revealed that the mass was a rare type of leiomyoma, a lipoleiomyoma. Microscopically, it contained an admixture of spindle smooth muscle cells with mature adipocytes. Patient recovered uneventfully after overcoming urinary retention.

V305

Robotic Left Adrenalectomy for Large Pheochromocytoma in Patient with Hereditary Leiomyomatosis and Renal Cell Carcinoma Syndrome (HLRCC).
Valentina Valle, MD; Alberto Mangano, MD; Gabriela Aguiluz, MD; Nicolas Dreifuss, MD; Dustin Baldwin, MD; Francesco Bianco, MD; Eduardo Fernandes, MD, PhD, FRCS; University of Illinois at Chicago

Hereditary Leiomyomatosis and renal cell carcinoma syndrome (HLRCC) is an autosomal dominant condition characterized by a germline mutation of the Fumarate Hydratase (FH) gene. Subjects affected by this mutation have a predisposition to develop multiple leiomyomas and renal and adrenal neoplasias.

We present a video of a robotic left adrenalectomy performed for a large pheochromocytoma in a patient affected by FH deficiency. At the time of surgery, a 0.6 GIST was also found in the body of the stomach, which was resected laparoscopically. In the video we show the technique adopted for the robotic left adrenalectomy.

V306

Laparoscopic TME with Intraoperative ICG Injection
Francesco CRAFA, Dr; Serafino Vanella, Dr; Benedetto Neola, Dr; Tommaso Palma, Dr; Adele Noviello, Dr; St. Giuseppe Moscati Hospital.

Prevent Anastomotic leakage (AL) remains the goal of rectal surgery. We present a case of 68-year-old man patient with rectal cancer underwent laparoscopic rectal resection with cTME. A Circular Powered Stapler was used to construct a tension-free colorectal anastomosis. Anastomosis and resection margins were investigated using fluorescence angiography intraoperatively. The anastomosis was directly visualized by intraoperative colonoscopy, confirming its integrity. Intraoperative tests early identify the main risk factors for AL and allow for repair.
V307

**Laparoscopic Re-Sleeve Gastrectomy for Residual Fundus After Initial Sleeve Gastrectomy**

Francisca Muñoz, MD; Fernando Muñoz; Ignacio Gonzalez; Universidad de los Andes; Hospital Militar de Santiago.

Case of a woman of 33 years old, with initial BMI 40 kg/m². She present 2 months after a sleeve gastrectomy with nausea, vomiting, unable to eat or drink water. Admitted to our Hospital, in the admission laboratory presented with ferropenic anemia, leukopenia and elevated CRP. The barium swallow study show a remanent fundus. We perform a re-sleeve gastrectomy.

V309

**Gastric Bypass in a Patient With Intraoperative Finding of Type IA Intestinal Malrotation**

Hugo E Estrada González, MD; Uriel Reyes Ramírez, MD; Axel Sánchez Pacheco, MD; Luis de la Puente Murguía, MD; Giuseppe Briceño Saenz, MD; Rodrigo Bucio Jaime, MD; Víctor M Pinto Angulo, MD; Hospital Juárez de México; Hospital Angeles Morelia.

We present the case of a female 38 years old with diagnosis of morbid obesity, diabetes, arterial hypertension, who was subjected to a gastric bypass “Roux en Y”. As an intraoperative finding we found an intestinal malrotation IA type, with fixed intestinal loop at the abdominal right side by right fixed ligament of Treitz. We adapt the perform of the digestive bypass to this finding raising the intestinal loop to the gastric pouch trough the right side to the mesocolon by the antemesocolic way.

V310

**Redo, Redo, Hiatal Hernia, Mesh, Magnetic Sphincter Augmentation & Gastric Bypass – Making Sure You Have All The Tools in Your Tool Box Prior to Operating**

Jasmina Ehab; Joseph A Sujka, MD; Michelle Lippincott, MD; Chris G Ducoin, MD; University of South Florida

This is a 55-year-old man who had previously undergone sleeve gastrectomy with hiatal hernia repair (HHR) and Redo HHR with mesh. He presented with severe GERD, esophagitis, and hernia recurrence. He underwent Timed Barium Swallow, Manometry, and IGD. Given his presentation, we recommended a Robotic HHR with Magnetic Sphincter Augmentation (MSA), with possible gastric bypass for GERD if MSA was not feasible. The patient’s adhesive disease made placement of the MSA device hazardous and we performed a Subtotal Gastrectomy with RYGB as alternative treatment. This underscores the importance of a complete surgical toolbox when proceeding with redo foregut surgery.

V311

**Minimally Invasive Management of Gastric Adenocarcinoma in the Setting of Bloom Syndrome**

Angela E Thelen, MD; Sarah N Redmond; Amelia Dorsey, MD; Kevin El-Hayek, MD, FACS; Department of Surgery, University Hospitals Cleveland Medical Center, Cleveland, OH; Case Western Reserve University School of Medicine, Cleveland, OH; Department of Surgery, MetroHealth System, Cleveland, OH.

This video describes the minimally invasive management of a young patient with gastric adenocarcinoma in the setting of Bloom Syndrome. After the incidental discovery of a gastric mass on screening endoscopy, the patient underwent a robotic-assisted wedge gastrectomy, which was positive for invasive gastric adenocarcinoma, immediately followed by a robotic-assisted total gastrectomy. In patients with Bloom Syndrome, it is imperative to maintain a high index of suspicion for malignancy and cancer screening is of the utmost importance. Furthermore, a minimally invasive approach in the setting of malignancy is reasonable, given its association with fewer postoperative complications and comparable outcomes.
V312

Emergent Choledochoscopy in the Setting of Pancreatitis Using a Novel Disposable Choledochoscope

Salvatore Docimo, DO; Kevin Seeras; Aurora Pryor; Stony Brook Medicine.

63 year old female who presented to our emergency room with complaints of epigastric and right upper quadrant tenderness. Her work up demonstrated elevated total and direct bilirubins. The CT scan and ultrasound findings were limited due to previous placed spinal hardware. We utilized a novel, disposable choledochoscope to assist in performing a transcyctic choledochoscopy to clear the common bile duct of previous undiagnosed common bile duct stones. We also utilized the scope to ensure the common bile duct was clear of all stones by advancing the scope into the duodenum. The patient was discharged home on post-operative day one.

V314

Robotic Low Anterior Resection with En Bloc Hysterectomy with Vaginal Extraction for Locally Advanced Rectal Cancer Involving the Cervix.

Artvom Khurshudyan, MD; Edwin A Alvarez, MD; Ankit Sarin, MD, MHA; University of California, San Francisco.

We are presenting the case of a 66 year-old female with locally advanced rectal cancer involving the cervix. We utilized a minimally invasive technique in which the rectum and sigmoid colon en block with the uterus, the cervix, the ovaries, and the fallopian tubes, were delivered through the vagina. After the rectum was mobilized, the uterus, ovaries, and vagina were dissected and mobilized, but left attached to the rectum for complete cancer excision. The technique is facilitated by the visualization and dexterity provided by robotic-assisted laparoscopy and may decrease morbidity and improve quality-of-life for women with locally invasive rectal cancer.

V313

Robotic Assisted Spigelian Hernia Repair

Brian Walkowski, MD; Brown University.

This video details a robotic assisted laparoscopic repair of a left sided 3×3 cm spigelian hernia in a 44 year old female. The hernia is repaired primarily followed by a synthetic, macroporous mesh overlap in the preperitoneal space. There were no complications.

V315

A Novel Technique for Laparoscopic J-Tube Insertion

Simon A Macdonald, MD; Daniel G French, MD, MASc, FRCSC; Dalhousie University.

In this video we display what we believe to be a novel technique for the laparoscopic placement of a feeding jejunostomy tube. Utilizing laparoscopic suturing as well as a suture passer, the procedure demonstrated is very similar to the one done via a laparotomy. We feel our technique is easily learned and could be replicated at most centres.
V316

Transoral Endoscopic Excision of Cystic Hygroma Vestibular Approach in Adults: A Noval Approach
Simran R Khatri, MBBS MS General Surgery; Bhupesh Tirpude, MBBS MS General Surgery; Gayatri Deshpande, MBBS MS General Surgery; Vidhey Tirpude; GMC Nagpur.

Background: Although cystic hygroma is well recognized in pediatric practice, it may present in adulthood also. We here, are reporting the endoscope excision of cystic hygroma via vestibular approach and explore its safety and feasibility.

Method: A 51-year-old female with swelling over the anterior aspect of the neck, transillumination positive. We decided to go for transoral endoscopic vestibular approach for excision, first of its kind with no assisted approach.

Conclusion: Transoral endoscopic excision of cystic hygroma via vestibular approach without any assisted approach can be applied safely and feasibly.

V318

Robotic Cholecystectomy of Left-Sided Gallbladder within the Falciform Ligament
Katrina M Pardo; Filipe Kunzler de Oliveira Maia, MD; Anthony M Gonzalez, MD, FACS, FASMS; Baptist Health South Florida

A 75-year-old female was noted to have a mass in the falciform ligament during foregut surgery. A postoperative CT showed a left-sided gallbladder with stones within the falciform ligament.

The patient underwent a robotic multiport cholecystectomy for the left-sided gallbladder within the falciform ligament. Fluorescent cholangiography using indocyanine green was used to identify the biliary anatomy. The use of all 4 arms in the robotic platform facilitated the retraction of the falciform ligament and gallbladder. The patient was discharged on postoperative day 1.

She returned a week later with an strangulated incisional hernia which was dealt with appropriately.

V319

Thoracoscopic Manual Repair of Intrathoracic Anastomosis During Minimally Invasive Ivor-Lewis Esophagectomy in Prone Position – A Black Video
Alfredo Annicchiarico, MD; Giorgio Dalmonte, MD; Marina Valente, MD; Gabriele Petracca, MD; Federico Marchesi, MD, PhD; Unit of General Surgery, Parma University Hospital.

Minimally invasive esophageal anastomosis still represents a surgical challenge. The use of circular staplers during thoracoscopy can be technically demanding, especially when the surgeon has to face a dilated or thickened esophagus.

In the video, after performing a stapled esophago-jejunal intrathoracic anastomosis in prone position, an intraoperative infiltrated resection margin forced us to extend further the esophageal resection and to redo the anastomosis. Unfortunately, the second anastomosis resulted incomplete for half of the circumference. We show how an effective manual repair of the anastomosis could be performed, avoiding further resection, even when the viscera have different calibers.

V320

Laparoscopic Transabdominal Preperitoneal Repair of a Morgagni Hernia with Defect Closure and Mesh Insertion
Amir Szold, MD; Ludovica Baldari, MD; Assia Medical, Assuta Hospital; Fondazione IRCCS Ca’ Granda Ospedale Maggiore Policlinico di Milano.

This video shows laparoscopic repair of an anterior diaphragmatic hernia with mesh insertion. Laparoscopic TAP and retrorectal block for pain control is performed. After reduction of the greater omentum, the hernia sac, with preperitoneal fat, is completely dissected from thoracic structures and diaphragmatic muscles. The complete mobilization of the sac allows a tension-free closure of the defect through non-resorbable barbed running suture. A 12 cm PVDF mesh is placed on the muscular layer and fixed to the diaphragm and to the abdominal wall with non-absorbable anchors. The peritoneal flap and the mesh are fixed together to the abdominal wall.
V321

Robotic Assisted Puestow in Complicated Chronic Pancreatitis
Nicole Hadjiloucas, MD1; Matthew Mackowsky, MD2; Stephen Pereira, MD1; Adam Rosenstock, MD1; George Mazpule, MD1; Adam Smith, MD1; 1Hackensack University Medical Center; 2Monmouth University Medical Center.

Objective: 64-year-old male with chronic pancreatitis with pseudocysts, and dilated pancreatic duct undergoes robotic assisted Puestow.

Case: Robotic assisted approach was utilized. Intraoperative ultrasound was used to identify the dilated pancreatic duct communicating with pancreatic pseudocyst. A pancreatojejunostomy was performed robotically along with cysto-jejunostomy. Patient tolerated the procedure well without complications.

Conclusion: Chronic pancreatitis can be debilitating in patients, especially who have failed endoscopic management of pseudocyst. Robotic Puestow procedure is a viable option and can lead to improved outcomes, shorter length of stay in the hospital and a quicker recovery period for the patient.

V322

Robotic Repair Of Large Symptomatic Morgagni Diaphragmatic Hernia
Lee A Farber, DO, FACOS, FACS; Vassar Brothers Medical Center.

Patient with shortness of breath, anorexia and abdominal pain. Had a large Morgagni Diaphragmatic Hernia. Morgagni hernias are not common and can be mistaken for other causes of chest pain, shortness of breath, anorexia, abdominal pain. These can be repaired safely with a minimally invasive approach. This patient underwent a successful Robotic Laparoscopic repair of her hernia with resolution of her symptoms and no complications, discharged on post operative day 2. Robotics allows us to perform complicated and intricate procedures utilizing a minimally invasive approach affording the patient less post operative pain, quicker recovery and less morbidity.

V323

Robotic Low Anterior Resection for Rectal Rosai Dorfman Disease
Joshua K Phillips, MD; Jason Zimmermann, MD; James Duncan, MD; Washington DC Veterans Affairs Medical Center.

This video depicts a robotic low anterior resection in a patient with Rosai-Dorfman Disease. Initial biopsy results were consistent with a gastrointestinal stromal tumor and final surgical pathology revealed this extremely rare tumor with fewer than 20 GI tract case reports in the literature. This video highlights the importance of adequate tissue sampling, benefit of ureteral ICG and the intense desmoplastic reaction created by this pathology. The importance of a sound pathology department to arrive at the correct diagnosis cannot be underestimated.

V324

Laparoscopic Repair of Perforated Gastrojejunal Ulcer and internal hernia
Yilon Lima Cheng, MD; Domenech Asbun, MD; Enrique F Elli, MD; Mayo Clinic Florida.

We report the case of a 58 year-old male who presented to the emergency department complaining of severe sudden onset abdominal pain. He had undergone a laparoscopic Roux-en-Y gastric bypass 2 years ago for morbid obesity. Prior medical history was concerning for repeated episodes of alcohol abuse. Imaging demonstrated a contained perforation at the gastrojejunostomy site with pneumoperitoneum and small volume free fluid. Laparoscopy was performed, and a perforated ulcer was repaired with a Graham patch. The patient also had a non-obstructing internal hernia that was addressed. No complications were registered.
V325

Laparoscopic Vertical Sleeve Gastrectomy Utilizing an Endoscope as a Bougie with Intra-operative Endoscopy and Longitudinal Imbrication of the Staple Line

Charles K Mitchell, Jr., MD, FACS, FASMBS; Bryan K Thomas, MD; Roper St. Francis Healthcare.

Laparoscopic Vertical Sleeve Gastrectomy is the most performed bariatric surgical procedure in the United States today. Gastric sleeve leak can be a catastrophic complication, and current surgical techniques are developed to prevent this problem. There is very little standardization in technique within MBSAQIP Comprehensive Centers across the country. We present this video to demonstrate the standardized technique within our practice, and discuss the rationale for its development and current use.

V326

Laparoscopic Repair of Recurrent Jejunal Diverticulitis

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A 71-year-old male presented to the ED with abdominal pain. He was diagnosed with a mesenteric abscess which was treated with antibiotics. His symptoms resolved completely. He returned to the ED a month later with similar symptoms. On CT he was found to have a localized perforated jejunal diverticulitis. Three days after treating with antibiotics he was taken for Exploratory Laparoscopy and resection of perforated jejunal diverticulitis. He recovered well and was discharged two days later. Two days after discharge, he presented with hematemesis. It resolved without any intervention. He has been followed up and is doing well.

V327

Laparoscopic Extended Total Mesorectal Excision with Presacral Fascia in a Case of Locally Advanced Rectal Cancer

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The concept of total mesorectal excision (TME) was the most important event in surgery for rectal cancer in the last two decades, decreasing both local recurrence and overall survival. Although Total mesorectal excision is the gold standard for rectal cancers, it may be essential to go beyond the mesorectal plane in certain unique situations, even after neoadjuvant therapy. This requires a surgical approach beyond the standard TME plane to enable complete resection of the tumor. Pre operative assessment of the extent of disease along with identifying the challenges prior to surgery are essential to obtain complete resection.

V328

Robot Assisted Laparoscopic Drainage of Pancreatic Fluid Collection with Necrosectomy

Claire Terez, MD; David Palange, DO; Adam Smith, MD; Stephen Pereira, MD; Adam Rosenstock, MD; George Mazpule, MD; Rutgers New Jersey Medical School; Hackensack University Medical Center.

Long term complications of acute pancreatitis include development of pancreatic fluid collections such as walled off necrosis and pancreatic pseudocysts. Their management continues to evolve and those that are symptomatic typically begin with percutaneous or endoscopic drainage. When these modalities fail patients are referred for surgical intervention. We present a case report demonstrating the feasibility of laparoscopic robot assisted transperitoneal pancreatic debridement.
Robotic Right Hemicolectomy Using a Modular Robotic System
Jeremy R Huddy, Mr; Ahmed S Nizar, Mr; Henry S Tilney, Mr; Frimley Health NHS Foundation Trust.
This video demonstrates a robotic right hemicolectomy using a novel modular robotic system. The patient was a 76-year-old male patient with a cancer 5 cm distal to the ileocaecal valve. Three bedside units were on the patients left for the visualization arm and two instrument arms. A further bedside unit was on the right for another instrument arm. Medial to lateral mobilization of the right colon was undertaken with both the ileocolic and right branch of middle colic artery divided robotically. The patient made a good post-operative recovery and was discharged home day 3. Histology confirmed pT3N1 adenocarcinoma with R0 resection.

Robotic-Assisted Transduodenal Ampullectomy and Duodenal Mass Excision with Common Bile Duct Exploration
Evander Meneses, DO; Nicole Yordan, MD; Amit Khithani, MD, FACS; Blake Babcock, MD, FACS; Limaris Barrios, MD, FACS; Alfredo Hernandez, MD, FACS; Miriam Canete; 1Kendall Regional Medical Center; 2Mercy Hospital.
A 62-year-old female presented with obstructive jaundice. She was found to have a duodenal bulb mass and a large ampullary mass. She underwent ERCP with stent placement, however the stent migrated to the right hepatic duct and she had a large free-floating gallstone. She underwent a robotic-assisted transduodenal excision of duodenal mass in D1 and removal of a mass at the ampulla of Vater with resection of the pancreatic and common bile ducts at the duodenum. Final pathology confirmed both masses were adenomas without invasive carcinoma. Her postoperative course was uneventful and she was discharged home after three days.

Modified Partial Anterior Fundoplication
Brian Hodgens, MD; Luke R Putnam, MD; Tayler J James, MD; Nikolai A Bildzukewicz, MD; John C Lipham, MD; University of Southern California.
This video demonstrates a modified partial anterior fundoplication that is more efficient than traditional antireflux surgery approaches while maintaining excellent outcomes. The technique creates a 180–270 degree, tension-free, anterior wrap of the fundus without requiring division of the short gastric vessels. It requires only four anchoring sutures and results in a several centimeter Hill Grade I flap valve. In our experience, this modified technique significantly reduces operative time as well as undesired side effects without compromising clinical effectiveness.

Robotic Surgery for an Unusual Case of Annular Pancreas in an Adult
David Fan, DO; Anthony Pozzessere, MD; Melissa Bagloo, MD; The Valley Hospital.
Annular pancreas is a rare, congenital, anomaly that usually presents as duodenal obstruction in neonates. It is one of the few congenital anomalies of the gastrointestinal tract, which can manifest in adulthood. In adults, factors initiating symptoms are pancreatitis, duodenal stenosis at the annulus, or duodenal/gastric ulceration. Operative management is preferred and involves duodenal bypass. Duodenojejunostomy is routinely performed in neonates, but in adults, the duodenum is less mobile, and duodenojejunostomy or gastrojejunostomy are recommended. We present a case of annular pancreas in a 22-year-old male that was treated successfully with robotic gastrojejunostomy with a highly selective vagotomy.
**V333**

Targeted Release of Twisted Wrap Through Per Oral Endoscopic Myotomy

Brooks V Udelsman, MD, MHS; Thomas Ward, MD; David Rattner, MD; Ozanan Meireles, MD; Massachusetts General Hospital.

Per Oral Endoscopic Myotomy (POEM) is an established treatment for achalasia. POEM is also a rescue for those with recurrent symptoms after a Heller myotomy. Here, we report an endoscopic esophageal myotomy along with release of a twisted wrap in a patient with recurrent achalasia 12 years after a laparoscopic heller myotomy with Toupet fundoplication. Intraoperatively, a submucosal tunnel was created and esophageal myotomy performed. Endoscopically, a bar of tissue was causing compression of the esophagus, which corresponded to the prior wrap on laparoscopic evaluation. A targeted endoscopic myotomy was performed relieving the compression.

**V335**

Laparoscopic Removal Of Copper-T Intrauterine Device A Multidisciplinary Approach

Lairah M Untao, MD, DPOGS; Marie Janice S Alcantara-Boquiren, MD, FPOGS, FPSRM, FPSGE; Southern Philippines Medical Center.

Intrauterine Device (IUD), an effective and reversible contraception has benefits however complications may occur. Uterine perforation is uncommon, serious complication that warrants immediate surgical removal. A 34-year old woman presented with hypogastric pain after Copper-T IUD insertion. Displaced IUD with uterine perforation was shown in transvaginal sonography. She underwent Diagnostic Hysteroscopy, Cystoscopy, Colonoscopy and Laparoscopic Removal of Copper-T IUD. In cases of displaced IUD with uterine perforation, early diagnosis is essential and Minimally invasive methods, such as hysteroscopy, cystoscopy, colonoscopy or laparoscopy, are ideal and preferable surgical approach.

**Key Words:** IUD, Uterine perforation, transvaginal sonography, hysteroscopy, cystoscopy, colonoscopy, laparoscopy.

**V334**

Repair of Perforated Gastrojejunal Ulcer after Mini Gastric Bypass

Muhammad U Khan, MD; Christine Tat, MD; Juan S Barajas-Gamboa, MD; Carlos Abril, MD; Ricard Corcelles, MD; Javed Raza, MD; Matthew Kroh, MD; Cleveland Clinic Abu Dhabi.

31 year old male w a history of mini gastric bypass in 2015 presented with acute abdominal pain. He reported a history of heavy smoking and NSAID use. CT showed free air. Patient was taken to the OR and was found to have perforated gastrojejunal anastomotic ulcer. This video depicts the repair of perforated gastrojejunal ulcer. Patient did well post-operatively. In the bariatric surgery population, smoking and NSAIDs are major risk factors for gastrojejunal anastomotic site ulceration and perforation.

**V336**

Resection of Leiomyomatosis From the Pelvic Side Wall and Sigmoid Colon

Shantel Jiggetts, MD1; Lauren Harris, MD2; William Burke2; Michael Pearl2; 1Maimonides Medical Center; 2Stony Brook University Hospital.

The objective is to present a unique case of leiomyomatosis and to display surgical techniques used to resect large fibroids from technically challenging locations on the pelvic sidewall and the sigmoid colon. The video was recorded using the Da Vinci Xi robot and demonstrates the approach, entry, surgical techniques, and outcome following the surgery. The purpose of the surgery was to remove two large fibroids. Contained morcellation was used to remove fibroids. The patient was called on postoperative day 1 and had a telehealth visit 4 weeks postop.
Laparoscopic Right Hemicolecction with Complete Mesocolic Excision for Neuroendocrine Tumour

Jonathan Ramkumar, Dr; Lazar Klein, Dr; Humber River Hospital, University of Toronto.

This video is of a laparoscopic right hemicolecction with complete mesocolic excision in a T3N2 neuroendocrine tumour. We start with a medial to lateral approach to the right colon. We dissect our vascular pedicles to their root at the superior mesenteric artery and vein for a high ligation. We complete our mobilization of the right colon and transect our proximal and distal margins with laparoscopic staplers. Once the dissection is complete, one can see the duodenum, pancreatic head, superior mesenteric vein, and superior mesenteric artery exposed. Finally, we perform an intracorporeal anastomosis before specimen extraction.

Leak After Gastropexy in Patient with Morbid Obesity and Large Paraesophageal Hernia

Emily E Mackey, MD; Nicole B Cherng, MD; John J Kelly, MD; University of Massachusetts Medical Center.

This video shows repair of a leak after a gastropexy in a patient with morbid obesity and large symptomatic paraesophageal hernia. Given her morbid obesity (BMI 59), she underwent a laparoscopic gastropexy, with plans for more definitive repair after weight loss. On postoperative day 7, she developed nausea, vomiting, and poor PO intake. Chest xray showed likely recurrence of the hernia. She was taken back to the OR and underwent a diagnostic laparoscopy, and was found to have a recurrence of the hernia, leak, and area of necrotic stomach. The area of necrosis was resection and the hiatus closed.

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