1184

GRACILIS MUSCLE INTERPOSITION FOR RECURRENT RECTOVAGINAL FISTULA

Sumeyye Yilmaz, Marianna Maspero, Raymond Isakov, Jean Wong, Niamh Foley, Anna R. Spivak, Tracy L. Hull

Treatment of rectovaginal fistulas (RVFs) is challenging and oftentimes requires multiple procedures. Current treatments range from simple local procedures to complex perineal and abdominal operations. Gracilis flap repair is recommended for recurrent and complex RVFs. The gracilis muscle has a very proximal pedicle, which makes it convenient for perineal transposition. The gracilis muscle provides healthy well-vascularized tissue that can be placed over the repaired internal anorectal opening and this will separate the internal opening from the repaired vagina. This video describes the technique of gracilis muscle interposition for recurrent RVFs.

1185

BRIDGE ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD)

Shaimaa Elkholy, Karim Essam, Hany Haggag, Abeer A. Abdellatef, Kerolis Yousef, Dalia Abd El-Kareem, Mohamed El-Sherbiny

Classic steps of ESD are marking, injection, circular incision followed by submucosal dissection. However, multiple modification had been made to make it much easier. For example, Pocket creation method in which a short tunnel is created below the lesion. Here we present Bridge technique in ESD in which we start with the oral (ceacal side of the lesion) followed by anal side (forward) and then communicating both together forming a bridge. This bridge will help a lot in performing counter traction that helps in easier & more precise dissection with limiting the use of traction devices especially in the colorectal lesions.

1186

TWO APPROACHES ARE BETTER THAN ONE: MANAGEMENT OF A LARGE CIRCUMFERENTIAL RECTAL POLYP USING A COMBINED OPEN AND TRANSANAL MINIMALLY INVASIVE SURGICAL APPROACH

Louis B. Shaevel, Justin Maykel, Tess Aulet

Large rectal polyps can present a challenge as to the feasibility of excision and the best approach when circumferential and spanning a long distance in the rectum. A 71-year-old-man had been living with a carpeting villous adenoma for many years developed worsening mucus drainage affecting his quality of life. Given there was no evidence of malignancy based on work up, excision was recommended to avoid radical resection or proctectomy. This case highlights the combined use of both open and minimally invasive transanal approach to excision of a large rectal polyp.

1187

ENDOSCOPIC RESECTION OF GIANT PEDUNCULATED POLYPS

Shaimaa Elkholy, Karim Essam, Hany Haggag, Abeer A. Abdellatef, Kerolis Yousef, Dalia Abd El-Kareem, Mohamed El-Sherbiny

Large pedunculated polyps are usually managed either by endoloop application or clips & EMR. However, in huge pedunculated polyps with large heads piecemeal resection was the only resort or surgery for the fear of expected significant bleeding. Here we present a series of huge pedunculated polyps head 6cm & stalk 3 cm. In the first patient multiple clips were applied to the base to minimize the bleeding followed by dissection the stalk with the knife & getting out the lesion enbloc. Another large twin polyp was noted almost occluding the hepatic flexure resected with ESD to the base of the pedicle.Thinking outside the box to avoid invasive procedure as surgery or suboptimal solutions as pEMR

1188

LAPAROSCOPIC REDO ENDORECTAL PULL-THROUGH PROCEDURE FOR COMPLEX RECTOVAGINAL FISTULA AFTER RECTAL RESECTION FOR ENDOMETRIOSIS.

Sergio Eduardo Alonso Araujo, Francisco Tustumi, Ana S. Portilho, Lucas S. Gerbasi, Rafael Vaz Pandini, Marleny N. Figueiredo, Lucas de Araujo Horcel, Marilia Marcelino, Rafaela d. Novo, Elis Oliveira, Victor Edmond Seid

A 36 years old woman underwent rectal resection with colpotomy for endometriosis. The patient presented an anastomotic leak and colpotomy breakdown, and a laparoscopic lavage of pelvic fecal peritonitis with a protective ileostomy was performed. Patient developed a rectovaginal fistula. We performed a pull-through procedure with delayed anastomosis associated with the repair of the vaginal defect and ileostomy closure. The coloanal anastomosis was performed 8 days after the pull-through procedure. A new rectovaginal fistula recurrence was observed, and a new redo pull-through was performed. Further resection of the colonic stump with a coloanal anastomosis after 18 days was uneventful.

1189

ANORECTAL FISTULECTOMY WITH GRACILIS MYCOCUTANEOUS FLAP REPAIR

Louis B. Shaevel, Justin Maykel

We present a 62-year-old male with a ten-year history of a complex fistula-in-ano leading to chronic purulent drainage. MRI showed a high blind tract extending from the perianal skin to the levator muscles and examination under anesthesia failed to reveal any communication with the anal canal or rectum. With limited options, we opted to perform a wide excision of the chronic tract and cavity. The defect was filled with healthy muscle harvested from the right thigh and skin was closed primarily.

1190

CHALLENGES AND SOLUTIONS FOR TTC DEFLECTING GRASPER-ASSISTED TISSUE RETRACTION DURING ESD

Neil Mitra, Hansani N. Angammana, Yanni Hedjar, Hmc Shantha Kumara, Richard L. Whelan

This video regards a controllable bendable endoscopic grasper now available for use in conjunction with a double channel therapeutic upper endoscope that facilitates ESD. This presentation considers use of this system in the rectum/sigmoid. For ESD, the grasper system can be used for the latter 50- 65% of the case. This system permits active retraction of the cut edge which improves exposure. The device design and limitations are explained and the numerous technique modifications necessary to accommodate this tool are presented. Video from ex vivo bovine colon ESD cases is included. Multiple ways in which the device can be used to provide traction and potential pitfalls are discussed.

1191

NEVER LETTING THE SUN RISE OR SET ON ADULT INTUSSISCEPTION: AN INTERESTING CASE

Beatrice Dionigi, Jacob Kimbill, Debbie Bakes, James Church, Ravi P. Kiran

Frail 86 yo woman diagnosed on CT at local community hospital with ileocolic intussusception. General surgery and GI agreed on no intervention and patient was discharged. A day later, she represented to the ER with worsening abdominal pain. Repeat CT showed worsening of a colo-colonic intussusception now extending to descending colon. She was transferred to our tertiary center and brought emergently to the operating room. Large mass in cecum intussuscepted into descending colon. Early management of adult intussusception is imperative. Surgical resection should be done promptly without delays at time of diagnosis especially if a long tract of intussuscepted colon is identified on imaging.

1192

ROBOTIC VENTRAL MESH RECTOPEXY

Sumeyye Yilmaz, Emre Gorgun

Treatment of pelvic organ prolapse is complex, and several operations are described for the surgical treatment. Ventral mesh rectopexy involves anterior rectal mobilization, placement of a synthetic or biologic mesh between the rectum and vagina and rectal fixation to the sacral promontorium by the mesh. While mesh serves as a support between the rectum and vagina, limited anterior rectal mobilization provides protection of the nerves, and decreased postoperative complications. In this video, we present technical tips and tricks of robotic ventral mesh rectopexy.

1193

LAPAROSCOPIC/ENDOSCOPIC MAGNETIC SIDE-TO-SIDE DUODENO-ILEOSTOMY

Michel Gagner, Lamees Almutlaq

Classical gastrointestinal anastomoses have been made with sutures and/or metal staples, but have resulted in significant bleeding and leak rates. This video is demonstrating a compression anastomosis using magnets to achieve weight loss and remission of co-morbidities. A linear magnet was delivered by flexible endoscopic catheter to a point 250 cm proximal to the ileocecal valve, and a second magnet was positioned in the first part of the duodenum; the bowel segments containing the magnets were apposed to initiate gradual incisionless compression. Laparoscopic assistance was used to obtain accurate bowel measurements, obviate tissue interposition, and close mesenteric defects.

1194

MINIMALLY INVASIVE RESECTION OF GASTROESOPHAGEAL JUNCTION GASTROINTESTINAL STROMAL TUMOR (GIST) IN PATIENT WITH A LARGE PARAESOPHAGEAL HERNIA

Yara Samman, Sarah Samreen

Gastrointestinal stromal tumors (GIST) are the most common mesenchymal neoplasms of the gastrointestinal tract with an annual incidence of 10-15 cases per million. Overall, they account for 0.1%-3.0% of all gastrointestinal tumors. GISTs take time to grow and become