

clinically expressed, therefore they are commonly an incidental finding. They appear throughout the gastrointestinal tract, however the most common site is the stomach followed by the small intestines, and rarely the rectum or esophagus. Gastroesophageal junction (GEJ) GISTs are extremely rare. We present a case of a unique resection, via DaVinci robot, of a GIST at the GEJ in a patient with type IV paraesophageal hernia.

1195

MODIFIED LAPAROSCOPIC SLEEVE GASTRECTOMY WITH EPIPHRENIC DIVERTICULECTOMY, HELLER MYOTOMY AND DOR FUNDOPLICATION

Edward Gray, Jad Khoraki, Guilherme M. Campos

We present a modification to a Laparoscopic Sleeve Gastrectomy (LSG) for the combined treatment of Class II obesity and an epiphrenic esophageal diverticulum in a patient with a relative contra-indication to a gastric bypass. The patient had a BMI of 39, ESRD on hemodialysis awaiting a Renal Transplant. A large epiphrenic diverticulum was found on endoscopy, and UGI Swallow confirmed a right posterolateral diverticulum, with preserved esophageal peristalsis. Technical highlights include hiatal and diverticulum dissection and diverticulectomy, Heller myotomy, Dor Fundoplication and hiatus closure. Lastly, the modified LSG preserving the part of the fundus used for the fundoplication.

1196

GASTRIC PER ORAL PYLOROMYOTOMY AND ENDOFLIP COMBINED APPROACH FOR MANAGEMENT OF GASTROPARESIS

Clayton O. Rooks, Ashley E. Williams, Jacob R. Moremen

Preoperative EndoFLIP was done to characterize the pylorus. The distensibility index (DI), minimum diameter (Dmin), and cross sectional area (CSA) were assessed and recorded at 40 and 50 mL fill volumes. Orise gel was then injected into submucosal space. Mucosal incision was made and submucosal plane was developed with monopolar cautery until duodenal fibers were seen over pyloric ridge. A retrograde circular myotomy was made with cautery. The mucosotomy was closed with running suture. Postoperatively, EndoFLIP was performed at the same site and volumes. The final DI, Dmin, and CSA at 50 mL increased from 6.7 to 7.5 mm2/mmHg (12%), 18.7 to 19.6 mm (5%), and 276 to 303 mm2 (10%) respectively

1197

ROBOTIC ASSISTED MEDIAN ARCUATE LIGAMENT SYNDROME (MALS) RELEASE

kelly zhang, alejandro Feria, amelia Dorsey, Sergio Bardaro, Kevin El-Hayek

48 y/o male with several year history of chest discomfort, that became worse in the past 15 months. Postprandial pain was usually 4/10. The cardiac workup was negative for abnormalities. EGD was normal. The patient had a CT ABD/PELVIS which showed celiac artery narrowing. Patient had a celiac plexus block which relieved the pain for 4-6 hours. CTA showed moderate to high-grade narrowing of the proximal celiac trunk. Uneventful postoperative course. Denied nausea or vomiting. No further postprandial pain. Tolerated diet progressively. Discharged home on POD 1 Robotic-Assisted MALS release is a safe and effective procedure when significant narrowing of the celiac artery is observed.

1198

ROBOT ASSISTED MEDIAN ARCUATE LIGAMENT RELEASE WITH ICG DELINIATION OF VASCULAR ANATOMY

Brian R. Davis, Michael Cutshall, Richard W. McCallum

We present a 41 year old male with multiple admissions for chronic nausea, emesis, post prandial abdominal pain, and weight loss. Celiac Duplex US and angiography were consistent with MALS revealing elevated peak systolic velocity (PSV) and compression of the celiac artery. Pre operative Duplex US showed elevated PSV that increased during expiration. A robotic approach with ICG was utilized to help delineate vascular anatomy. After median arcuate ligament release, Celiac Duplex US showed decrease in PSV to normal value. Patient had near total relief of symptoms post operatively.

1199

ROBOTIC ASSISTED SURGICAL MANAGEMENT OF MEDIAN ARCUATE LIGAMENT COMPRESSION SYNDROME AND GASTROPARESIS

Adel Hanandeh, Kevin El-Hayek, Sergio Bardaro

Median arcuate ligament syndrome (MALS) is rare etiology of postprandial abdominal pain and feeding intolerance. Due to its vague clinical presentation, it is often missed leading to prolong patient suffering prior to accurate diagnosis and treatment. Median arcuate ligament syndrome is multifactorial encompassing vascular malperfusion due to celiac artery compression and neurogenic symptoms due to celiac ganglion compression. In this case we are describing the utility of robotic assisted surgical interventions to obtain accurate median arcuate release using intra-operative robotic assisted duplex US and Infrared Fluorescence imaging to ensure adequate celiac artery perfusion.

1200

TECHNICAL DETAILS AND EARLY RESULTS OF MODIFIED LAPAROSCOPIC SLEEVE GASTRECTOMY WITH HIATAL HERNIA REPAIR AND TOUPET FUNDOPLICATION

Guilherme D. Mazzini, Jennifer Salluzzo, Guilherme M. Campos

Patients with clinically severe obesity and GERD have better GERD outcomes with a laparoscopic gastric bypass (LRYGB) when compared to a laparoscopic sleeve gastrectomy (LSG). However, some patients with GERD may have a contraindication to undergo LRYGB and modifications to LSG to include an anti-reflux fundoplication have been used to allow offering a LSG to patients with GERD. In this video we present the key technical aspects of a modified LSG with hiatal hernia repair, a partial posterior 270° fundoplication, and initial clinical results in 15 patients. Long-term GERD outcomes and potential advantages of a partial fundoplication added to an LSG are still under scrutiny.

1201

PUSHING THE LIMITS OF LAPAROSCOPY IN COMPLEX ACUTE CARE SURGERY (ACS)

Winnie Feng, Nathaniel Rubalcava, Paul R. Del Prado

Laparoscopy in ACS can prove challenging, compared to the traditional laparotomy. However, in medically complex patients, it may decrease morbidity and shorten recovery. We present a systematic approach to these cases that includes: 1) 4-quadrant evaluation, 2) local irrigation, 3) endoscopic leak test, and 4) wide drainage. We demonstrate the efficacy of this algorithm in 2 case studies. A 64 yo man with CAD, CKD, and BMI 40 had a 3-cm gastric perforation and underwent a partial gastrectomy without post-op complications. A 78 yo man with Child C cirrhosis, COPD, and pulmonary HTN had a perforated D1 ulcer repaired with an omental patch. His post-op bile leak was successfully managed non-op.

1202

LAPAROSCOPIC SLEEVE GASTRECTOMY AND LARGE HEPATIC HEMANGIOMA RESECTION

Alec Haas, Sergio Bardaro, clara M. Lai, MetroHealth M. Center, Alec Haas, Alec Haas, Alec Haas, Alec Haas

We present a 53 y/o female with morbid obesity (BMI 57) with multiple comorbidities as well as GERD and h/o postprandial epigastric pain. Previous CT showed a left hepatic exophytic mass. Subsequent MRI showed to be a cavernous hemangioma (approximately 6 cm in diameter). The hemangioma was overlying the GEJ. We planned for a simultaneous laparoscopic liver resection and sleeve gastrectomy. However, during the procedure we also observed a hiatal hernia as well as an umbilical hernia that we repaired simultaneously. We consider that simultaneous advanced complex operations are safe in combination with bariatric surgery, when performed by an experience team in a tertiary care center.

1203

ENDOSCOPIC FULL THICKNESS RESECTION OF A GASTRIC GIST & CLOSING THE DEFECT WITH PURSE STRING SUTURE

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

The classic resection techniques including EMR/ESD had always been targeting the mucosa & submucosal layers. But if the muscle layer is involved this is named FTR. Free handed FTR; resecting the lesion first leaving a hole that should be closed. Sometimes closure devices like suturing devices are expensive & not available. we present a simple way that can effectively close a perforation. Purse string suture; in which the endoloop is applied to the edges of the defect with hemoclips & then followed by endoloop closure closing the whole defect perfectly. We demonstrate FRT of a gastric GIST about 2.1x 2.9 cm from the fundus of the stomach & closing the defect with purse string suture.

1204

LAPAROSCOPIC TRANSGASTRIC REMOVAL OF AN ERODED GASTRIC BAND

Veeshal H. Patel, Ashton B. Christian, Ninh T. Nguyen

We present a case of a 37 year old man with morbid obesity (BMI 52) who was 5 years status-post laparoscopic gastric band placement. He presented with right sided abdominal pain at the location of his subcutaneous port, secondary to an ascending infection from an eroded gastric band. Through a combined laparoscopic and endoscopic approach, successfully removed the gastric band via a distal gastrotomy, and closed this defect with a stapled partial gastrectomy. The patient had resolution of his pain post-operatively and was discharged home on POD 1. We discuss our technical transgastric approach, key points in regard to identification and transection of the band, and possible pitfalls.