Found 15 Abstracts

ABSTRACT FINAL ID: V1;

TITLE: Gastric Pouch and Stoma Reduction Using a Novel Endosurgical Operating System

AUTHORS/INSTITUTIONS: M. Ryou, D. Mullady, D.B. Lautz, C.C. Thompson, Division of Gastroenterology, Brigham & Women's Hospital, Boston, MA; L. Swanstrom, , Legacy Health Sciences, Portland, OR; M. Bessler, , Columbia Presbyterian Hospital, New York City, NY; D.M. Herron, , Mount Sinai Hospital, New York City, NY;

ABSTRACT BODY:

Background: Weight regain in gastric bypass patients can be mediated by dilation of the gastric pouch and dilation of the gastrojejunal anastomosis (stoma). An endoscopic means of addressing these complications could prove highly useful.

Methods: The Endosurgical Operating System (EOS) was used for gastric pouch and stomal reduction in 18 gastric bypass patients who had experienced weight regain.

Results: In 18 patients, stomas were decreased from a mean of 25 mm to 6mm using a mean of 4 tissue anchors. Three months following the procedure, suture anchors remained intact in 4 patients who underwent follow-up endoscopy. All four had lost at least 15 pounds.

Conclusion: The Endosurgical Operating System effectively reduces gastric pouches and stomas. It may potentially represent a likewise effective, minimally-invasive option for addressing weight regain in gastric bypass patients.

ABSTRACT FINAL ID: V2;

TITLE: The Trans-Gastric Endoscopic Rendezvous Technique (TGER)

AUTHORS/INSTITUTIONS: S. Karmali, J. Sweeney, V. Sherman, , Baylor College of Medicine, Houston, TX;

ABSTRACT BODY:

Background: The utility of the Molina nonadjustable gastric band for the treatment of morbid obesity was common in the 1980s. Unfortunately, it was associated with an unacceptable re-operative and complication rate. One unfortunate complication was gastric erosion. Removing such a band that has eroded into the stomach can be fraught with difficulty due to the extensive inflammatory response around the proximal stomach and left lobe of the liver. To circumvent the aforementioned difficulties, we have devised a trans-gastric endoscopic rendez-vous (TGER) technique for the removal of eroded Molina non-adjustable gastric bands.

Methods: Two patients who presented with symptoms secondary to an eroded Molina gastric band were reviewed. Our TGER technique was utilized in both patients to remove the eroded gastric band.

Results: The TGER technique was successful in removing the eroded gastric band in both patients. Patient 1 was discharged on post-operative day two and remains symptom free at 6 months post-operation. Patient 2 was discharged on post-operative day one and was seen post-operatively at 3 months at which time the patient requested placement of an adjustable gastric band which was successfully completed.

Conclusion: The TGER appears to be a useful technique to apply to the difficult situation of an eroded Molina gastric band. Utilization of a combined endoscopic/laparoscopic approach is preferred over a completely laparoscopic technique since the area of adhesions surrounding the previously banded stomach is wholly avoided. Herein we found it surgically less arduous to secure a gastrotomy in virgin tissue rather than opening and then closing the capsule, which is necessary when removing an eroded gastric band open or laparoscopically.

ABSTRACT FINAL ID: V3;

TITLE: Endoscopic Sclerotherapy for Dilated Gastrojejunostomy after Gastric Bypass

AUTHORS/INSTITUTIONS: A.K. Madan, K.A. Khan, D.S. Tichansky, Surgery, University of Tennesee Health Science Center, Memphis, TN;

ABSTRACT BODY:

Background: Roux-en-Y gastric bypass is an excellent option for weight loss in the morbidly obese. Unfortunately, some patients do have weight regain or insufficient weight loss. Revisional bariatric surgery is not without risk. Less invasive techniques may provide alternative treatments for weight regain or insufficient weight loss. This video will demonstrate a technique of endoscopic sclerotherapy for dilated gastrojejunostomy after gastric bypass.

Methods: The technique is applied to patients who have had weight regain or insufficient weight following gastric bypass. Patients who have lost the feeling of satiety, undergone re-education and re-counseling of dietary changes, and have documented dilated gastrojejunostomy on upper endoscopy and/or a barium study are offered this technique. If the gastojejunostomy is larger than 12 mm, sodium morrhuate is injected with an endoscopic needle circumferentially.

Results: The gastrojejunsostomy is injected with 6 – 30 cc of sodium morrhuate. By visual inspection, the anastomosis usually appears smaller after the procedure. Most patients report a subjective feeling of satiety after the endoscopy sclerotherapy. Re-injection after 3 months has been performed in patients who lose their feeling of satiety and have a gastrojejunostomy greater than 12 mm. Except mild nausea, the patients have experienced no morbidity or mortality from the procedure.

Conclusion: Endoscopic sclerotherapy may offer an alternative treatment of dilated gastrojejunstomy after gastric bypass. The technique described in the video is a relatively easy and safe method that may become the first line of therapy in patients who lose the feeling of satiety after gastric bypass.

ABSTRACT FINAL ID: V4;

TITLE: Laparoscopic Restoration of Gastrointestinal Continuity After Duodenal Switch

AUTHORS/INSTITUTIONS: G. Dapri, G. Cadière, J. Himpens, , European School of Laparoscopic Surgery, Brussels, BELGIUM;

ABSTRACT BODY:

Background: Duodenal switch (DS) for morbid obesity has excellent results in terms of weight loss, but also side-effects due to malabsorption. We report a laparoscopic restoration of gastrointestinal continuity for invalidating diarrhea, unresponsive to conservative treatment.

Methods: In August 2005 a laparoscopic DS was performed on a 43-years women, with a BMI of 54 Kg/m2. An entirely handsewn duodenoileostomy was performed besides a totally mechanical jejunoileostomy, the common limb measured 75 cm and the alimentary limb 175 cm. After 3 months the patient presented significant diahrrea and after 9 months the common limb was lengthened by laparoscopy. After the following 6 months diarrhea affected again the patient, hence she requested a restoration of gastrointestinal continuity. The BMI at the time was 24 Kg/m2. The sequence of the procedure was: 1) adhesiolysis 2) deconstruction of the duodenoileostomy and isolation of the duodenal stump, 3) construction of an end-to-end duodenoduodenostomy by entirely double-layers handsewn method, 4) identification of the alimentary loop, the jejunoileostomy and the biliopancreatic loop, 5) section of the biliopancreatic limb near the jejunoileostomy, 6) construction of the side-to-side jejunojejunostomy by semimechanical technique, 7) closure of the mesenteric defect, 8) leak-test.

Results: Operative time was 105 min and estimated blood loss was 20 ml. Patient had an uneventful recovery and was discharged on 8th p.o. day. At 3 months the patient was asymptomatic, and the BMI was 36,2 kg/m2. At 6 months the BMI was 42 kg/m2, and the barium swallow showed good transit through the gastrointestinal tract.

Conclusion: Malabsorption of DS is no longer irreversible since restoration of gastrointestinal continuity is technically feasible by minimal invasive means. This conversion however carries the risk of weight regain.

ABSTRACT FINAL ID: V5;

TITLE: Laparoscopic Conversion of a Distal Mini-Gastric Bypass to a Proximal Roux-en-Y Gastric Bypass for Malnutrition

AUTHORS/INSTITUTIONS: E. Arias, P. Fajnwaks, R. Rojas, S. Szomstein, R. Rosenthal, , Cleveland Clinic Florida, Weston, FL;

ABSTRACT BODY:

Background: Malnutrition is an uncommon complication after Roux-en-Y gastric bypass (RYGBP).

Methods: This case report describes a 44-year-old female who underwent a distal mini gastric bypass (MGB) for morbid obesity at another institution. She presented to our clinic with a one-year history of muscle pain, severe lower extremity edema, diarrhea, a body mass index (BMI) of 25 kg/m2, a total protein level of 4.3 g/dl, and an albumin of 1.7 g/dl. She was diagnosed with chronic malnutrition. Laparoscopic placement of a feeding gastrostomy tube was performed three months before revisional surgery, in order to provide enteral feeding and correct the malnutrition. Once the prealbumin levels were within normal range and the pitting edema resolved, the patient underwent laparoscopic revisional surgery

Results: Exploration of the small bowel was carried out from the ligament of Treitz to the ileocecal valve. A common channel of approximately 80 cm was identified with a long narrow gastric pouch and a loop gastroileostomy. The small bowel was transected distal to the gastroileostomy without narrowing the ileal lumen. The gastric pouch was subsequently shortened and horizontally transected. The jejunum was divided 50 cm from the ligament of Treitz. A gastrojejunostomy and jejunojejunostomy were performed in a standard fashion, resulting in an antecolic antegastric proximal gastric bypass with a 100cm alimentary limb and a 50cm biliopancreatic limb. The patient's postoperative course was uneventful; at a 6 month follow up, there was no evidence of malnutrition.

Conclusion: Laparoscopic conversion of a distal MGP to a proximal RYGBP is feasible, effective, and safe.

ABSTRACT FINAL ID: V6;

TITLE: Transoral Endoscopic Closure of a Gastric Fistula

AUTHORS/INSTITUTIONS: M. Schweitzer, K.E. Steele, P. Okolo, M. Mitchell, J. Lyn-Sue, Surgery, Johns Hopkins University, Baltimore, MD;

ABSTRACT BODY:

Background: A 45 year old female who had a previous failed gastroplasty in the 1980's underwent an open revision to duodenal switch with biliopancreatic diversion. Two weeks after the operation she presented with a gastric leak into an abscess that was drained under CT guidance. Three months later she continues to have a gastrocutaneaus fistula despite two overlapping stents and fibrin glue injection.

Methods: The patient underwent transoral endoscopic gastric fistula closure in the operating room under general anesthesia. A combination of methods were used to close the tract. The opening was first coagulated with the argon beam and then scraped with a cytology brush. Fibrin glue was injected into the tract. The opening was at the gastroesophageal junction which made it more difficult to close and therefore, the Stomaphyx plicating device was used to bring the medial wall of the fisutla tract closer to the lateral wall. Endoscopic clips were then used to close the opening.

Results: The gastric fistula was completely closed.

Conclusion: We now have multiple transoral endoscopic methods to close gastric leaks and fistulas after bariatric surgery. Stents, fibrin glue, clips, and suture devices all have a role in trying to achieve adequate closure. A major advantage of the transoral endoscopic route is that it can be repeated.

ABSTRACT FINAL ID: V7;

TITLE: Laparoscopic Gastric Bypass after Previous Nissen Fundoplication

AUTHORS/INSTITUTIONS: S.Q. Nguyen, A.A. Sabnis, D.M. Herron, , Mount Sinai School of Medicine, New York, NY;

ABSTRACT BODY:

Background: Gastroesophageal Reflux Disease (GERD) in the morbidly obese is best managed with Roux-en-Y Gastric Bypass. However, some patients present with GERD prior to weight gain and undergo Nissen Fundoplication. Others might have presented to a surgeon unfamiliar with bariatric surgery.

Methods: We present a video of a morbidly obese 71-year-old male who had previously undergone a Nissen Fundoplication and was seeking weight loss surgery.

Results: A decision was made to proceed with a Laparoscopic Gastric Bypass. There were a few important considerations. Dense adhesions to the left lobe of the liver, the anterior wrap, and gastroesophageal junction should be expected. The fundus of the stomach should be completely mobilized back to its normal anatomic position in order to safely create the gastric pouch. Lastly, the proximal gastric remnant may become ischemic as it is no longer vascularized by the short gastric or left gastric vessels. These points are clearly demonstrated in our video. Our patient had no complications after his procedure and was discharged to home on post-operative day two.

Conclusion: In conclusion, this video showed that Laparoscopic Gastric Bypass can be safely and successfully accomplished after Nissen Fundoplication.

ABSTRACT FINAL ID: V8;

TITLE: Laparoscopic Revision of VBG to RYGB with Large Hiatal Hernia

AUTHORS/INSTITUTIONS: H. Naim, M.A. Fobi, , St. Mary Medical Center, Long Beach, CA;

ABSTRACT BODY:

Background: As the number of primary Bariatric procedures increases, there is a demand for revisions of complications, as well as failed primary procedures. These challenging operations can be done with minimaly invasive techniques which privides better exposure and all the benefits of laparoscopic approach to the patient.

Methods: Here we present a case of failed Vertical Banded Gastroplasty which is complicated with Large Hiatal Hernia. The opertion involved reduction of the pouch from the chest, repair of the Hiatal Hernia, take-down of the vertical gastroplasty, and revision to Roux-En-Y Gastric Bypass.

Results: The procedure was completed laparoscopicall without any post-operative complication. The length of stay was three nights. The options exist to creat the new pouch out of the old one. We elected to reconstruct the original anatomy to prevent possiblity of creating a closed segment by having two staple lines crossing. We believe this staple line crossing lateral to the pouch , at the angle of Hiss, could be an etiology for delayed leak in this area.

Conclusion: Laparoscopc revision of Bariatric procedures are safe and can be attempted by experienced bariatric surgeons with extensive training in Laparoscopic surgery. The issue of crossing previous staple line needs to be kept in mind when stapling the stomach. The use of longer Green stapler is critical. We present one technique which includes taking down the gastroplasty along with repair of Hiatal Hernia followed by conversion to Gastric Bypass.

ABSTRACT FINAL ID: V9;

TITLE: Laparoscopic Magenstrasse and Mill Procedure

AUTHORS/INSTITUTIONS: E. Valin, U. McMillian, K. Arroyo, Surgery, Hospital of Saint Raphael, New Haven, CT;

ABSTRACT BODY:

Background: Laparoscopic sleeve gastrectomy is becoming a more popular restrictive bariatric procedure. However, 80% of a normal stomach is removed. The Magenstrasse and Mill procedure is an established bariatric operation similar to the sleeve gastrectomy without the removal of normal stomach. This is the first laparoscopic Magenstrasse and Mill video presentation.

Methods: One 5mm subxiphoid port is placed and removed, the tract is used for the Nathanson liver retractor. Three 10/12 ports across the upper abdomen are used to perform the procedure. A 21mm EEA stapler is used to create the initial button window 5cm-6cm from the pylorus in the creation of the tubular gastric pouch. A 34fr oro-gastric tube is used to size the pouch.

Results: see video

Conclusion: A laparoscopic Magenstrasse and Mill procedure can be performed; it is less invasive/radical than a sleeve gastrectomy as a restrictive bariatric procedure.

ABSTRACT FINAL ID: V10;

TITLE: Laparoscopic Roux-en-Y Gastric Bypass in a Patient with the Entire Small Bowel in a Congenital Hernia Sac

AUTHORS/INSTITUTIONS: A.A. Nimeri, K.D. Higa, K.B. Boone, A. Khan, Surgery, UCSF Fresno Medical Education Program, Fresno, CA; A. Jackson, , Advanced Laparoscopic Surgery Associates, Fresno, CA;

ABSTRACT BODY:

Background: Bariatric surgery is the most effective weight loss managment option for patients who meet the NIH criteria for surgical intervention. Laparoscopic Roux en Y gastric bypass is the commonest procedure performed in the United States. Our patient was found to have a congenital sac covering the entire small bowel with small bowel malrotation.

Methods: This is a video of a patient undergoing primary antecolic antegastric laparoscopic Roux en Y gastric bypass surgery after opening the congenital sac.

Results: After the sac covering the entire small bowel was opened. We elected to perform an antecolic Roux limb because of the malrotation of the small bowel. In addition the gasto-jejunostomy was performed first followed by performing the jejuno-jejunostomy. Our technique is to perform a vertical pouch based on the lesser curve of the stomach, create a retrocolic antegastric Roux en Y gastrojejunostomy performing the jejuno-jejunostomy first.

Conclusion: Laparoscopic Roux en Y gastric bypass surgery can be safely performed in patients with congenital sac covering the entire small bowel and small bowel malrotation

ABSTRACT FINAL ID: V11;

TITLE: Treatment of Chronic Obstruction as a Late Complication of an Adjustable Gastric Band

AUTHORS/INSTITUTIONS: K.M. Reavis, M.W. Hinojosa, B.R. Smith, N.T. Nguyen, , University of California, Irvine, Orange, CA;

ABSTRACT BODY:

Background: Erosion and slippage are potential late complications after laparoscopic adjustable gastric banding. Obstruction is also a potential late complication related to the development of a fibrotic scar at the level of the band. In this video, we demonstrate our laparoscopic technique for removal of the band with division of the fibrotic scar combined with endoscopic balloon dilation.

Methods: Our patient is a 42 year old male who underwent laparoscopic adjustable gastric banding four years previously. The patient had 83% excess body weight loss but presented recently with progressive dysphagia and persistent vomiting. Complete band deflation was performed; however, an upper GI study continued to show a high-grade obstruction at the level of the band.

Results: Intraoperative upper endoscopy revealed a tight obstruction at the level of the band with sedimentary deposit. The endoscope was unable to be passed through the obstruction site. Laparoscopy was performed and the band was removed. Additionally, a segment of the fibrotic scar at the level of the band was removed. Despite removal of the fibrotic scar and band, we were not able to pass the endoscope through the obstruction site. Endoscopic pneumatic dilation was performed and the scope was then easily passed into the distal stomach. The operative time was 90 minutes with minimal blood loss. The upper GI contrast study on postoperative day one showed normal flow without evidence of obstruction.

Conclusion: Laparoscopic band removal with scar excision combined with endoscopic pneumatic dilation is an effective method for relieving chronic obstruction after laparoscopic adjustable gastric banding.

ABSTRACT FINAL ID: V12;

TITLE: Laparoscopic Reduction of Small Bowel Intussusception in a 33-week Pregnant Gastric Bypass Patient

AUTHORS/INSTITUTIONS: G.M. Eid, A. Tohamy, Minimally Invasive and Bariatric Surgery, University of Pittsburgh Medical Center, Pittsburgh, PA;

ABSTRACT BODY:

Background: Small bowel intussusception in adults following gastric bypass surgery is an uncommon but previousely reported complication. Most reported cases are retrograde in nature, mainly involving the common channel. A probable etiology includes the presence of an ectopic pacemaker causing retrograde peristalsis. Patients usually present with intermittent abdominal pain or recurrent episodes of bowel obstruction. Reduction of post-operative small bowel intussusception via the open approach has been widely used due to many technical challenges of the laparoscopic approach.

Methods: A case of small bowel intussusception in a 33 week pregnant gastric bypass patient that was treated using the laparoscopic approach.

Results: Successful reduction of intussusception was achieved using the laparoscopic approach. No small bowel resection was needed. No evidence of recurrence at 9 months follow-up.

Conclusion: Intussusception is an uncommon complication of gastric bypass surgery. Based on our experience, laparoscopic reduction of intussusception is safe and feasible approach. Small bowel resection may not be needed unless bowel ischemia is identified.

ABSTRACT FINAL ID: V13;

TITLE: Intussusception as a Late Complication of Laparoscopic Roux-en-Y Gastric Bypass

AUTHORS/INSTITUTIONS: A.C. Cordova, N.A. Spinelli, F.J. Scholz, D. Nepomnayshy, , Lahey Clinic Medical Center, Burlington, MA;

ABSTRACT BODY:

Background: Intussusception is a rare clinical entity in the adult population, particularly in patients who have previously undergone Roux-en-Y gastric bypass. It is responsible for 1 percent of all intestinal obstructions in adults and 90 percent of the time it is secondary to a definable pathologic lesion.

Methods: A 29-year-old female with a history of Roux-en-Y gastric bypass six years ago, with an excess weight loss of 58%, presented complaining with abdominal pain and emesis. Abdominal CT scan showed findings consistent with bowel obstruction secondary to intussusception. The patient was taken to the operating room urgently. An impressive mass of intussuscepted small intestine involving the jejunojejunostomy was found. Resection of the mass with reconstruction of the Roux-en-Y configuration via two separate anastomosis was necessary. The patient was discharged home on the 5th postoperative day.

Results: Although most general intussusceptions occur in an isoperistaltic manner, those associated with previous Roux-en-Y gastric bypass occur in an antiperistaltic fashion. Moreover, they commonly occur just distal to the jejunojejunostomy or actually involve this anastomosis, as in the described patient. The etiology of these retrograde intussusceptions is unclear, but it is thought to center around dysmotility in the Roux limb. Management is surgical and small bowel resection is commonplace due to irreversible ischemia. At times, reconstruction of the entire Roux-en-Y anastomosis is necessary due to the inability to reduce a large intussusception involving the jejunojejunostomy.

Conclusion: In patients with history of Roux-en-Y gastric bypass, intussusception occurs in an antiperistaltic fashion. Computarized tomography is valuable in establishing a preoperative diagnosis. It is a potential severe complication and requires early recognition and intervention.

ABSTRACT FINAL ID: V14;

TITLE: Laparoscopic Roux-en-Y Gastric Bypass Revision for Gastrogastric Fistula Following Previous Open Roux-en-Y Bypass

AUTHORS/INSTITUTIONS: M. Morales, A.A. Wheeler, R. de la Torre, J.S. Scott, General Surgery, University of Missouri in Columbia, Columbia, MO;

ABSTRACT BODY:

Background: Our objective is to demonstrate the complexity but technical feasibility of a laparoscopic Roux En Y Gastric Bypass in a patient with a gastrogastric fistula following previous Open Laparoscopic Roux En Y Gastric Bypass.

Methods: A 33 year old female three years out from open Roux En Y Gastric Bypass (RYGB presented with decreased satiety and increased oral intake. She also reported a 78lb increase in weight. Upper gastrointestinal study demonstrated a large gastric pouch with contrast into the gastric remnant. Esophagoduodenoscopy revealed a gastrogastric fistula. The patient underwent a laparoscopic RYGB revision with gastrogastric fistula resection. Our technique consisted of:

identification and dissection at the Angle of His, take-down of Short Gastric Vessels, take-down of gastrogastric fistula with creation of new gastric pouch, resection of partial remnant stomach and previous roux limb, creation of revised jejunojejunostomy with 50cm BP limb

and 100cm roux limb, transesophageal introduction of anvil into the revised pouch and creation of gastrojejunostomy.

Results: The patient underwent a successful laparoscopic RYGB revision and gastrogastric resection. Postoperative UGI and oral blue dye studies demonstrated no evidence of anastomotic leak. She was discharged on POD two.

Conclusion: Laparoscopic Roux en Y Gastric Bypass revision of

previous open Roux en Y Gastric Bypass is a challenging but technically feasible procedure.

ABSTRACT FINAL ID: V15;

TITLE: Laparoscopic Placement of an Adjustable Gastric Band in a Super-Super Obese Patient with Situs Inversus

AUTHORS/INSTITUTIONS: E.M. Pauli, I. Wadiwala, A.M. Rogers, Department of Surgery, Penn State College of Medicine, Hershey, PA;

ABSTRACT BODY:

Background: This video shows a reverse-orientation laparoscopic placement of an adjustable gastric band in a patient with situs inversus and a BMI of 60.

Methods: The patient had a history of Kartagener's syndrome and severe bronchiectasis leading to progressive pulmonary fibrosis. Candidacy for lung transplantation required her losing a considerable amount of weight.

Results: The patient successfully underwent laparoscopic gastric banding with ports placed in a mirror-image orientation and with low pressure pneumoperitoneum.

Conclusion: She is doing well in follow up.