Video Sunumlar / *Video Presentations*

03 Ekim 2015, Cumartesi *- October 3, 2015 (Saturday)* **Salon C** - Hall

15.00 – 16.40	**7. Oturum** - 7th Session **Video Sunumlar (Serbest Bildiriler) /** Accepted Video Presentations (Free Papers)	
15.00 – 15.10	***VP-001***	Sleeve Gastrectomy in a Patient of Situs Inversus Totalis - *Digvijay Singh Bedi*
15.10 – 15.20	***VP-002***	Da Vinci Large Sliding Hiatus Hernia Repair with Bio-Prosthetic Mesh Reinforcement for Severe GERD in a Patient 24 Months Out of Laparoscopic Sleeve Gastrectomy – *Sofiane El Djouzi*
15.20 – 15.30	***VP-003***	Laparoscopic Fundoplication with a Great Curvature Plication is Satisfactory Simultaneous Treatment for Severe Obesity and GERD - *Akzhunis Orekesheva*
15.30 – 15.40	***VP-004***	Laparoscopic Revision of Roux-en-Y Gastric Bypass with Gastrogastric Fistula Takedown, Hiatal Hernia Repair, and Partial Remnant Gastrectomy for Symptomatic Large Gastrogastric Fistula - *Sofiane El Djouzi*
15.40 – 15.50	***VP-005***	Laparoskopik Sleeve Gastrektomi Kaçağına Laparoskopik Tedavi Yaklaşımı - *Onur Birsen*
15.50 – 16.00	***VP-006***	Laparoskopik Sleeve Gastrektomi Ameliyatlarında Yaşadığımız İntraoperatif Sorunlar ve Tedavi Yöntemleri - *Muhammed Raşid Aykota*
16.00 – 16.10	***VP-007***	Stapler Hattına Sütur Konulması Rutin Gerekli mi? - İsmail Cem Sormaz
16.10 – 16.20	***VP-008***	Laparoskopik Sleeve Gastrektomi Sonrasında Oluşan Kronik Fistülün Endoskopik Tedavisi - *Rıza Gürhan Işıl*
16.20 – 16.30	***VP-009***	Endoscopic Stenting for the Treatment of Leaks and Strictures After Sleeve Gastrectomy - *Veysel Umman*
16.30 – 16.40	***VP-010***	Endoscopic Removal of Eroded Gastric Bands – *Selen Soylu*

[VP-001]

Sleeve Gastrectomy in a Patient of Situs Inversus Totalis

Digvijay Singh Bedi

Hope Obesity Centre, Department of Bariatric and Metabolic Surgery

Laparoscopic Sleeve Gastrctomy in a Patient With Situs Inversus Totalis

Situs inversus totalis is a congenital anomaly present in approximately 0.01% of population. In this anomaly there is complete mirror image reversal of all the abdominal and thoracic organs. Presenting a case of 45 year old male with situs inversus totalis. His BMI was 42 and had co-morbidities like hypertension and dyslipidemia. He was posted for laparoscopic sleeve gastrectomy after the complete work up.

Method: Patient was placed in supine position and ports were placed according to the need of the condition that patient had. Standard sleeve gastrectomy was performed using 36F gastric calibration tube.

Result: Post operative course of the patient was uneventful and the patient was discharged on the second postoperative day with dietary advice.

Conclusion: Laparoscopic sleeve gastrectomy can be performed safely in a patient with situs inversus totalis by experienced laparoscopic surgeon.

Keywords: Situs inversus, sleeve gastrectomy

[VP-002]

Da Vinci Large Sliding Hiatus Hernia Repair with Bio-Prosthetic Mesh Reinforcement for Severe GERD in a Patient 24 Months Out of Laparoscopic Sleeve Gastrectomy

Sofiane El Djouzi

Weight Loss Surgery, Poplar Bluff Regional Medical Center, Poplar Bluff, USA

Gastroesophageal reflux disease (GERD) and hiatus hernia (HH) are prevalent in morbidly obese patients. The severity of the associated symptoms correlates with body mass index. Although concomitant HH repair at the time of LSG is common and advocated by many, there are few data on the da Vinci role and the best approach in HH repair after LSG.

Methods: This is a video presentation of Da Vinci large sliding hiatus hernia repair with Bio-prosthetic mesh reinforcement. The patient is a 46-year-old female who had suffered from refractory de-novo GERD associated with severe chronic anemia since her LSG done 24 months prior. The associated near-disabling dysphagia led to a significant weight loss (347 lbs down to 171 lbs).

Results: The surgery was non-complicated with minimal EBL. UGI on POD # 1 showed no leak or obstruction with complete reduction of the hiatus hernia and no contrast refluxing into the esophagus. Diet was well tolerated before discharge home on POD # 1. All preoperative GERD related complaints and chronic anemia have resolved on follow-up visits. The patient stopped taking PPIs and expressed full satisfaction.

Conclusion: A few lessons were learned from this case. First of all, the dexterity and the 3D capabilities of Da Vinci show a high precision of dissection in revisional surgery. Secondly, posterior cruroplasty with bioprosthetic mesh reinforcement are of significant benefit in the management of symptomatic GERD even after LSG. Finally, hiatus hernias should ideally be repaired at the time of LSG.

Keywords: Hiatus Hernia, Sleeve Gastrectomy, GERD

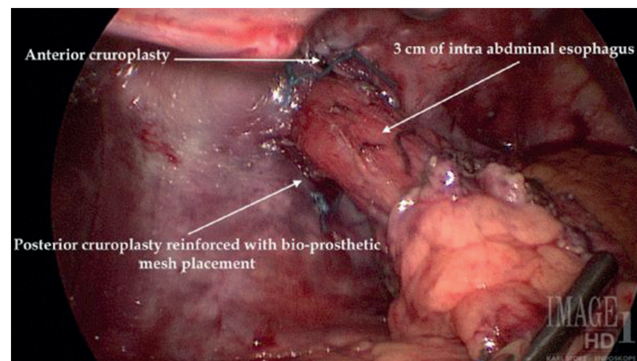

Figure 1. Intraop pic

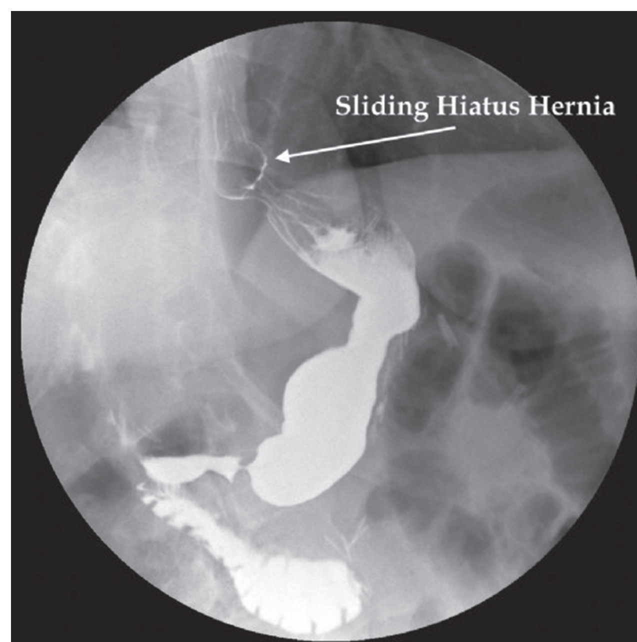

Figure 2. Preop UGI

[VP-003]

Laparoscopic Fundoplication with a Great Curvature Plication is Satisfactory Simultaneous Treatment for Severe Obesity and GERD

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Background and study aims: Obesity often leads to problems of heartburn and regurgitation, which fall under the category of gastroesophageal reflux disease (GERD). The study compares two

types of procedures and the aim is to identify if it is possible to treat both obesity and GERD at the same time.

Study Design: Data for pilot single-centre single-blind two-arm randomised controlled study were collected from January 2010 to December 2014. Inclusion criterion was a combination of GERD and obesity with a body mass index (BMI) of 35 to 39 kg/m2.

All patients (n=114) were randomly divided into 2 groups. Patients in the first group (n=56) were performing laparoscopic fundoplication combined with great curvature plication, in the second group (n=58) including only Floppy Nissen procedure.

Mean duration of surgery, excess weight loss and DeMeester score were recorded.

Results: Duration of surgery was 97.28 ± 17.49 minutes in the first group and 59.64 ± 16.34 minutes in the second group (P <0.0001). The average excess weight loss in 24 months after the surgery in the first group was 43.71 ± 2.69%, in the second group 14.39 ± 3.56% (P <0.0001). The DeMeester score in the esophageal-gastric junction was found to be at 12.0 ± 4.3 in the first group and 11.3 ± 9.3 in the second group (P> 0.05).

Conclusion: Laparoscopic fundoplication with a great curvature plication is satisfactory simultaneous treatment for severe obesity and GERD.

Keywords: Laparoscopic, fundoplication, gastroplication, obesity, GERD.

[VP-004]

Laparoscopic Revision of Roux-en-Y Gastric Bypass with Gastrogastric Fistula Takedown, Hiatal Hernia Repair, and Partial Remnant Gastrectomy for Symptomatic Large Gastrogastric Fistula

Sofiane El Djouzi

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Background: Laparoscopic Roux-en-Y gastric bypass (RYGB) is the most commonly performed bariatric operation in the United States. Although rare, gastro-gastric fistulas (GGFs) are an important complication of this procedure. A certain proportion of those could be very symptomatic altering one's social and professional lives.

Methods: This is a video presentation of laparoscopic takedown of a large GGF with partial remnant gastrectomy and antecolic Roux-en-Y reconstruction. The patient is a 42-year-old female schoolteacher who had suffered from refractory GERD associated with dysphagia and chronic abdominal pain for ten years. Her original laparoscopic RYGB was done ten years prior.

Results: The surgery was non-complicated with minimal EBL. UGI study on POD # 1 showed no leak with satisfactory RYGB anatomy. The patient was discharged on POD # 2. She was followed in the office for over a year now. Her BMI dropped from 30.1 to 25.7. All her preoperative complaints resolved.

Conclusion: GGFs are uncommon, but worrisome, complication after divided RYGB. They can initially be managed with a conservative, non-operative approach as long as the patient remains asymptomatic and weight regain does not occur. They could also be associated with nearly disabling symptoms. Laparoscopic takedown of GGFs with partial remnant gastrectomy is a safe and effective treatment option. The corrective surgery is associated with no comorbidities and limited hospital stay.

Keywords: Gastrogastric fistula, Roux-en-Y gastric bypass

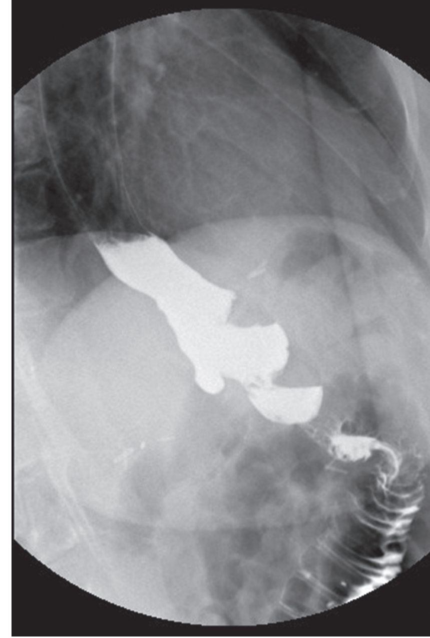

Figure 3. Postoperative UGI

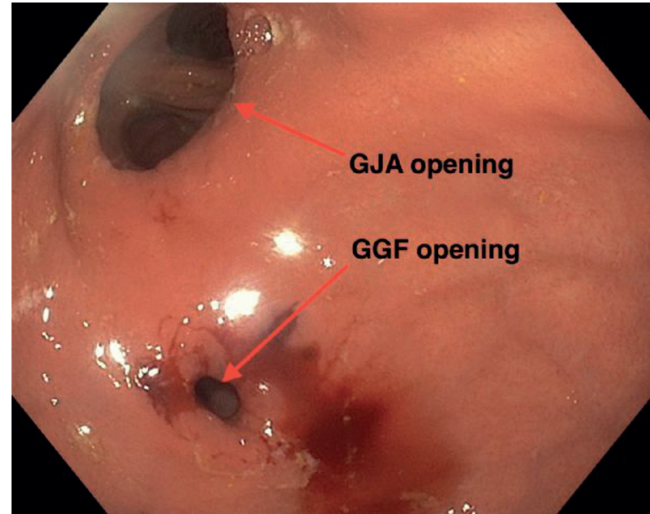

Figure 4. Preoperative EGD

[VP-005]

Laparoskopik Sleeve Gastrektomi Kaçağına Laparoskopik Tedavi Yaklaşımı

Onur Birsen, **Muhammet Rasid Aykota, Onur Kılıç, Utku Özgen, Murat Özban**

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Amaç: Laparoskopik Sleeve Gastrektomi (LSG) son yıllarda popüler olmuş, ülkemizde en sık yapılan bariatrik ameliyatlardan biridir. En korkulan başlıca komplikasyon kaçaktır.

Bu video ile post-operatif 10. günde kaçağı olan bir hastaya laparoskopik yöntemle kaçağa yaklaşım ve tedavi yönteminin tartışılması amaçlandı.

Olgu: 25 yaşında kadın hasta, başka bir ilde üniversite hastanesinde LSG ameliyatı oluyor. Ameliyat öncesi VKİ: 42,5kg/m² ve ek hastalığı yok. Hasta sorun olmadan 3. günde taburcu ediliyor. Ameliyattan 10 gün sonra hasta yüksek ateş ve karın ağrısı şikayeti ile üniversitemizin acil servisine başvuruyor. Hastaya torakoabdominal oral opaklı tomografi ile kaçak tanısı konulduktan sonra acil laparoskopik ameliyata alınıp karın yıkama ve drenaj işlemleri uygulandı. Ertesi gün hastaya endoskopik stent ve nazojejunal beslenme tüpü takıldı. Hasta yaklaşık 3 ay sonra şifa ile taburcu edildi.

Sonuç: Kaçak olgularında perkütan drenaj yapılamıyorsa açık ameliyata geçmeden önce hastaya laparoskopik ameliyat sansı verilmelidir. Bu gibi olgularda laparoskopik karın yıkama ve drenaj, stent uygulaması ve nazojejunal beslenme tüpü takılması konvansiyonel kaçak tedavi yöntemini oluşturmaktadır.

Anahtar Kelimeler: Laparoskopik sleeve gastrektomi; Bariatrik cerrahi; Gastrik Fistül; Kaçak

[VP-006]

Laparoskopik Sleeve Gastrektomi Ameliyatlarında Yaşadığımız İntraoperatif Sorunlar Ve Tedavi Yöntemleri

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Amaç: Laparoskopik Sleeve Gastrektomi (LSG) ülkemizde en sık yapılan bariatrik ameliyatların başında gelmektedir. İntraoperatif komplikasyon riski düşük olsa bile özellikle yeni başlayan merkezler bu sorunla karşı karşıya kalabilirler. Kliniğimizde 2013 yılından beri yapılan vakaların videoları izlenip, intraoperatif karşılaştığımız komplikasyonlar ve tedavi yolları yaklaşık 1-2 dakikalık videolar ile sunulmuştur.

1. Olgu: Stapler ın düzgün basmaması ve stapler hatası.
2. Olgu: Intra-operatif kanama ve tedavi yolları
3. Olgu: Yeterli görüş alanının sağlanamadığı durumlar
4. Olgu: Staplerin intraaoperatif kırılması

Sonuç: Bu videolar ile 2013 yılında beri karşılaştığımız intraoperatif sorunları göstermek ve tedavi yollarının anlatılması ve tartışılması amaçlanmıştır.

Anahtar Kelimeler: Laparoskopik Sleeve Gastrektomi; İntraoperatif komplikasyonlar; Kanama

[VP-007]

Sleeve Gastrektomide Cerrahi Teknik Sunum - Stapler Hattına Sütur Konulması Rutin Gerekli mi?

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Morbid obezite tedavisinde yaygın uygulanmakta olan sleeve gastrektomi cerrahi tekniğinde, oluşturulan mide tüpünün çapı, bırakılan antrum miktarı, kardiyada stapler hattının hiyatal kurusa olan mesafesi, kullanılan stapler çeşidi ve stapler hattının süture edilmesi gibi teknik detayların ameliyat sonrası erken ve geç dönem sonuçlar ile yakın ilişkili olduğu iyi bilinmektedir.

Bu video filmde uygulamalarımızda tercih ettiğimiz cerrahi teknik detayların sunulması amaçlanmıştır. Pilor 3 cm proksimalinden antrumda ilk siyah stapler yerleştirilmesini takiben 36 Fr sonda ile kalibrasyon yapılmakta ve 2. siyah stapler kullanıldıktan sonra mor kartuşlar ile tüpe yakın düz bir hatta devam edilmekte ve fundus – kardiya bileşkesinde ~ 1 cm mesafe bırakılarak rezeksiyon tamamlanmaktadır. Farklı yüksekliklerde 3 hatta kapanma özelliği olan kartuşlar sayesinde etkin hemostaz ve güvenli doku kapanması oluşmakta, stapler hattı mavi boya ile kaçak testini takiben süture edilmeden bırakılmaktadır.

Bazı ekipler hem hemostaza katkısı, hem de stapler hattını güçlendirmesi beklentisi ile rutin sütür uygulamaktadır. Ancak diğer taraftan stapler hattının boydan boya süture edilmesi, doku mikrosirkulasyonunu olumsuz etkileyebilmesi ve oluşturulan dar tüpün çapını değiştirebilmesi gibi potansiyel sakıncaları da beraberinde getirmektedir. Bizde uygulamalarımızda rutin sütur kullanmamaktayız. Stapler kartuş değişim noktaları ve proksimalde kardiya bölgesi gibi potansiyel riskli alanları gözlemlemekte ve gerekli gördüğümüzde separe sütur uygulamaktayız. Yeni nesil stapler kullanımı ve uygun kartuş seçimi ile, hem hemostaz hem de doku kapanma güvenliğinin sağlanması sayesinde rutin ilave sütur kullanımının gerekli olmadığını savunmaktayız.

Anahtar Kelimeler: Sleeve gastrektomi

[VP-008]

Laparoskopik Sleeve Gastrektomi Sonrasında Oluşan Kronik Fistülün Endoskopik Tedavisi

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Amaç: Günümüzde Laparoskopik Sleeve Gastrektomi ameliyatı ülkemizde en sık yapılan obezite ameliyatlarından biri olup operasyon sonrasında %3 ile %7 arasında fistül gelişimi bildirilmektedir. Oluşan fistüllerin en az morbidite ve mortalite ile tedavi edilmesi amaçtır. Bu video sunumunda Laparoskopik Sleeve Gastrektomi sonrasında oluşan kronik fistülün endoskopik tedavisini sunmayı amaçladık.

Olgu: 31 yaşında bayan hasta vki:50kg/m2 morbit obezite nedeni ile 06.05.2013 tarihinde Laparoskopik Sleeve Gastrektomi operasyonu yapıldı. Hasta 11.05.2013 tarihinde cerrahi şifa ile taburcu oldu. Hasta 17.07.2013 tarihinde sol 10' luk çalışma portunda kızarıklık ve ağrı şikayeti ile polikliniğimize başvurdu. Hastanın çekilen B.Usg ve Kontrastlı Tüm Batın Bt sinde post yerinde apse ile uyumlu görünüm bulundu. Apse drene edildi ve kültür alındı. Kültür sonucunda *e.koli* üredi. Hasta 23.07.2013 tarihinde cerrahi şifa ile tekrar taburcu oldu.

20.01.2015 tarihine kadar herhangi bir şikayeti olmayan hastanın gittikçe artan dispepsi ve karın ağrısı olması üzerine hastanemize tekrar başvurdu. Hastanın yapılan tetkiklerinde özofagokardiyak bileşkede fistül tractı ve yaklaşık 5*6 cmlik apse poşu saplandı. Hastanın apsesi girişimsel radyoloji ile birlikte drene edildi. Fistül tractı temizlendi. Apse poşu küçüldükten sonra hastaya Endoskopik olarak OTSC klip yerleştirildi. Hasta 30.02.2015 tarihinde cerrahi şifa ile taburcu edildi. Hastanın takiplerinde herhangi bir komplikasyon saplanmadı.

Hastanın şu anki vücut kitle indeksi 22.8 ve operasyon öncesi Tip 2 DM nedeni ile oral anti diyabetik kullanan preop HgA1c değeri 7.2 olan hasta tam remisyondadır.

Sonuç: Laparoskopik Sleeve Gastrektomi operasyonlarından sonra gelişebilen fistüllerin tedavisinde Percütan drenaj ve Endoskopik klip uygulaması deneyimli merkezler tarafından başarı ile uygulanabilen bir yöntemdir.

Anahtar Kelimeler: Sleeve Gastrektomi, Obesity, Endoscopic Prosedures

[VP-009]

Endoscopic Stenting for the Treatment of Leaks and Strictures After Sleeve Gastrectomy

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#Umraniye Teaching and Training Hospital Department of Internal Medicine

Objective: Sleeve gastrectomy is the most widely used single staged bariatric operation for the treatment of Morbid Obesity. Although it is considered as a simple and safe procedure early and midterm complications such as leaks and strictures can become fatal and morbid for the patient. Here in we would like to show a video and series of patients treated with covered stents whom either leaks and/or strictures developed after sleeve gastrectomy. We have used the stent in stent technique which seems to be as efficient as early re-do surgery in the control of the leaks and resolution of the strictures postoperatively.

Materials and Methods: 301 patients with a mean BMI of 43.4 were operated between 2011-2015 in Cerrahpasa Medical Faculty Department of General Surgery. There were 131 male and 170 female patients. Mean age was 38.6. All patients underwent gastrograffin swallow study on the third postoperative day after surgery. 14 patients developed leaks after surgery. 9 of them were diagnosed with the swallow study and 5 of them underwent a CT scan due to clinical manifestations of tachycardia and/or fever after surgery. The technique is demonstrated with the video.

Results: Out of 14 patients 12 patients underwent stent in stent placement due to either leaks or strictures. 7 patients with leaks underwent endoscopic covered stent in stent placement. 5 patients with strictures underwent firstly balloon dilatation and endoscopic stent in stent placement. 3 patients did not tolerated the stent. One with the stricture had excessive vomiting and nausea in the first 48 hours after surgery so the stent was removed and the patient was operated and R &Y total gastrectomy-esophagojejunostomy, was preferred due to the high nature of the leak. Other patient with stricture underwent an emergency surgery due to the migration and gastric rupture caused by the stent. Omegaloop gastric bypass was preferred due to the prepyloric nature of the stricture. Stents were removed in median time of 6 weeks and the mean hospital stay was 2 ±1.7 days for the stricture group and 6 ±2.6 days for the leak group.

Conclusion: Eventhough stent placemnt needs advanced endoscopic skills and causes discomfort in some patients, it is feasible and safe and avoids uncessary emergency surgery and decreases hospital stay and patient mortality incase of leaks.

[VP-010]

Endoscopic Removal of Eroded Gastric Bands

Selen Soylu[1], Ulgen Zengin[2], Veysel Umman[1], Ismail Demir[1], MustafaTaskin[1]

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Background: Laparoscopic Adjustable Gastric Banding is considered as a safe bariatric procedure providing adequate weight loss and metabolic control. In contrast, patients should be closely followed-up for minor and major long-term complications. Band erosions are common complications where patients present with persistent nausea, abdominal pain, weight gain and recurrent infection of the port and tubing system. Unless treated it can cause, fatal bleeding, mechanical bowel obstruction, even perforation. Here in we show a video description of an endoscopic removal of a complicated eroded gastric band and its endoscopic removal.

Methods: 38 years old male who underwent a laparoscopic gastric banding procedure 8 years ago. During his routine follow-up period she underwent a gastroscopy procedure due to chronic abdominal pain and nausea.

Results: Gastroscopy revealed almost fully migrated gastric band at the corpus of the stomach. The port is removed first under local anesthesia and than the eroded band was cut via endoscopic cutter system also the connecting tube is also removed along the band by a grasping snare.

Conclusion: All the (LAGB) patients with gastrointestinal symptoms, port infection and weight regain should undergo an endoscopic evaluation. Endoscopic removal of the band is feasible and safe and prevents unnecessary surgical interventions.