

v1. *LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS FOLLOWING KIDNEY PANCREAS TRANSPLANTATION. Carol A. McCloskey, MD; Ramesh C. Ramanathan, MD*

Background: This is a case report of a 47 year-old female 9 years status post kidney/pancreas transplantation for renal failure secondary to Type I diabetes. The organs were functional and the diabetes was in remission. However, the patient was morbidly obese with a body mass index (BMI) of 39.3, and had developed hypertension. Her immunosuppressant regimen included tacrolimus (FK506) and imuran.

Methods: A laparoscopic Roux-en-Y gastric bypass (LRYGBP) was performed. The donor pancreas/duodenum was located in the right lower quadrant and found to be anastomosed to the mid-jejunum, approximately 70cm from the ligament of Treitz. The jejunum was divided 30 cm distal to the pancreas, creating a 100cm biliopancreatic limb. A 70 cm Roux limb was created, and the gastrojejunostomy was performed in an antecolic, antegastric fashion.

Results: Postoperatively, the patient had a transient elevation in creatinine, peaking at 1.8 on postoperative day (POD) 3. This correlated with supra-therapeutic FK506 levels, peaking at 22.6 on POD6. The creatinine normalized following dose reduction.. At her one-month follow-up visit, she had a 27lb. weight loss. Her creatinine was 1.1, and her FK506 level was normal (5.3).

Conclusions: LRYGBP bypass is a feasible operation following kidney/pancreas transplantation. Challenges associated with performing this operation include: preventing injury to the transplanted organs in the setting of dense adhesions and altered anatomy, preventing renal failure from prolonged insufflation, and construction of the limbs in relation to the pancreas. Postoperatively, FK506 levels must be monitored to prevent peri-operative toxicity, and to assess for decreased levels due to malabsorption long term.

v2. *LAPAROSCOPIC-THORACOSCOPIC IVOR-LEWIS ESOPHAGECTOMY AFTER GASTRIC BYPASS. Ninh T. Nguyen, MD; Cam-Ly P. Tran, MD; Allen Sabio, BS; Peter Lin, MD; Esteben Varela, MD*

We present a case of a 51 year-old woman who was diagnosed with a gastroesophageal junction adenocarcinoma 5 years status post an open gastric bypass. She was taken to the operating room for a staging laparoscopy, lysis of adhesions, feeding jejunostomy tube placement 2 days prior to definitive esophagectomy. This video demonstrates the steps performed to take down the gastric bypass and perform the esophagectomy laparoscopically and thoracoscopically, respectively, using the gastric remnant as the gastric conduit.

v3. *ADVENTURES IN LAP BAND SURGERY: 'THE TROUBLESOME SLIP'. Nicholas A Bertha, DO; Steve Ugras, MD; Alexander Abkin, MD*

The video depicts a severe lap band slippage. The band was dissected from its position around the mid portion of the stomach. It was not possible to reduce the slippage. The band was intra-corporeally opened and removed from its tunnel. Recreation of an appropriate tunnel proximally was performed next and the same band was placed through that tunnel. The band was then reconnected to the port tubing extra-corporeally, an adhesion barrier was applied, and the procedure completed.

v4. *BASKET BAND: A NEW ADJUSTABLE GASTRIC BAND DEVELOPED TO AVOID PROXIMAL GASTRIC POUCH DILATATION. PRELIMINARY SERIES. Antonio Catona, MD; Giovanni Morone, MD; Rubina Ruggiero, MD; Luigi LaManna, MD; Antonio Parziale, MD; Bardh Spahia, MD; Francesco Luzzana, MD; Cristina Sampiero*

Background

Adjustable Gastric Banding (AGB) is the most popular bariatric procedure in Europe. The main complication of the procedure is gastric pouch dilatation: it affects quality of life and in case of acute onset, it requires emergency re-operation. For this reason we developed a new adjustable gastric band called Basket Band (BB). The band is a regular one with a soft silicone mesh above it, thought to envelope the proximal gastric pouch to prevent it from enlargement.

Methods

Since 1992, we implanted 1065 laparoscopic gastric bands: of these 40 were BB. Laparoscopic operation is quite different from the one of AGB. The technique is similar to the one for hiatal hernia with a wider freeing of gastric fundus. Once the band is passed around the stomach, the superior mesh envelopes the proximal gastric pouch.

Results

In BB group we had a 1 yr %EWL of 47.6% vs. a 40.8% in the AGB group. Even if it is too early to evaluate long term complications, we had no gastric pouch dilatations in the BB group vs. 6.6% in the AGB group. In the BB group nobody had vomiting or dysphagia.

Conclusions

Gastric pouch dilatation is an important complication of AGB. A mesh above the band could be the solution to the enlargement of proximal stomach. Even if this is a preliminary series, results in weight loss and complications are encouraging. Laparoscopic surgical technique is not as easy as in AGB and operative times are longer.

v5. *LAPAROSCOPIC BANDED ROUX-EN-Y GASTRIC BYPASS. Andrew A Gumbs, MD; Marc Bessler, MD*

Video presentation of the techniques involved with a laparoscopic banded Roux-en-Y gastric bypass. Rationale for the performance of this procedure as opposed to standard roux-en Y gastric bypass and the benefits of its use will be discussed. Port placement and all devices used will be highlighted.

v6. *LAPAROSCOPIC REVISION TECHNIQUE FROM LAP-BAND TO GASTRIC BYPASS WITH DISTAL ESOPHAGOPLASTY. Hadar Spivak, MD; Oscar R. Betran, MD*

Due to inadequate weight loss or complications, we have converted 32 patients from LAP-BAND to Roux-en-Y gastric bypass. These revisions account for about 5% of all patients in our series who underwent the LAP-BAND procedure and were followed for more than one year. In this video, we present the laparoscopic revision technique in addition to distal esophagoplasty in this particular patient due to distal esophageal dilation.

v7. *LAPAROSCOPIC PLACEMENT OF AN ADJUSTABLE GASTRIC BAND FOR DILATED GASTROJEJUNOSTOMY AFTER ROUX-EN-Y GASTRIC BYPASS (RYGBP). Ruth O'Mahony, MD; Samuel Szomstein, MD; Raul J. Rosenthal, MD*

Weight regain and dumping syndrome due to gastrojejunostomy dilatation and loss of restriction after divided RYGBP are relatively uncommon complications. Surgical techniques that have been described to correct these problems are placement of an adjustable gastric band or trimming of the dilated pouch.

We describe a laparoscopic approach during which the dilated anastomosis is narrowed with an adjustable gastric band in order to reestablish restriction. After lysis of adhesions is performed the angle of His and left crus of the diaphragm are identified. Dissection of the pouch from attachments to the gastric remnant is achieved with blunt and sharp technique. On the lesser curvature the right crus of the diaphragm is exposed. With a reticulating esophageal dissector a window is created behind the gastroesophageal junction. The band is wrapped around the distal portion of the pouch and secured with interrupted silk sutures. The port is secured to the abdominal wall fascia in a standard technique.

Laparoscopic adjustable gastric banding for dilated gastrojejunal anastomosis with weight regain or dumping syndrome is a feasible and safe technique. Our preliminary results with this approach show no morbidity and acceptable restriction.

v8. *LAPAROSCOPIC MANAGEMENT OF PERFORATED MARGINAL ULCER AFTER LAPAROSCOPIC ROUX EN Y GASTRIC BYPASS. Michael R. St. Jean, MD; Stephanie Dunkle-Blatter, MD; Anthony T. Petrick, MD*

Case presentation of a 53 year old female who presented with an acute abdomen 15 months after laparoscopic Roux en Y gastric bypass for morbid obesity. The patient had been treated by primary care manager for anastomotic marginal ulcer with proton pump inhibitors. An abdominal CT scan demonstrated intraperitoneal air in the area of the lesser omentum and above the liver without abscess. Video demonstrates mobilization of the remnant stomach and duodenum for possible sites of perforation. Dissection of the Roux limb and anastomotic junction is presented with simultaneous endoscopy. Identification of a posterior perforation in the area of chronic inflammation is confirmed endoscopically as well as laparoscopically. Oversewing of the perforation with jejunal and omental patching is performed. Next, dissection at the hiatus is initiated to localize and isolate the vagal trunks. Truncal vagotomy with hiatal closure is documented. Postoperative upper gastrointestinal series images are illustrated.

v9. *ADVANCED ENDOSCOPIC TECHNIQUES IN THE POST-BYPASS PATIENT: LEAKS AND FISTULA.* Christopher C. Thompson, MD, MHES; James Slattery, RN; Malcolm K. Robinson, MD; David B. Lautz, MD

This video details advanced endoscopic techniques helpful to the treatment of chronic post-operative leaks and fistula. The first case is that of an anastomotic leak that is treated with Microvasive Resolution clips and Tisseel fibrin glue and finally resolves after Polyflex stent placement. The last two cases are fistulae (gastro-gastric and jejuno-gastric) that are closed with endoscopic suturing.