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P001 - Abdominal Cavity and Abdominal Wall

Laparoscopic Preperitoneal Hernia Repair for Treatment Ventral Hernia (the Rectus Abdominal Diastasis, Flank Hernia and Recurrent Incision Hernia)

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Aims: Rectus abdominal diastasis, flank hernia and recurrent incision hernia are kinds of ventral hernia. The totally extraperitoneal hernia repair for inguinal hernia had already performed for many years. It had benefits at post operation hospitalization, wound pain, cosmetics. We believe that we can use the same approach for treatment the ventral hernia. We want to share our early experiences with this approach. We also evaluate the feasibility and post operation results.

Methods: We performed the preperitoneal hernia repair with mesh for treatment ventral hernia since 2011, had already performed 37 cases. In this case of rectus abdominal diastasis patients and right flank hernia patient and left lower abdomen recurrent incision hernia status post mesh hernia repair with right lower abdomen incision hernia were performed at 2017. The demographic information and defect size were measured.

Results: This rectus abdominal diastasis female was 41 years old. The rectal muscle distance about 7 cm. The operation time was about 4 hours. The right flank incision hernia male was 69 years old. The fascia defect was about 10×8 cm. The operation time was about 2 hours. The left lower abdomen recurrent incision hernia status post mesh hernia repair with right lower abdomen incision hernia female was 60 years old. The left lower abdomen fascia defect about 7×5 cm and right lower abdomen fascia defect about 2×2 cm. The operation time was about 4.5 hours. The 3 cases blood lose were about 5 ml. The wound pain was VAS:4 ~ 5. They discharged from our hospital within the 24 hours postoperative period. The seroma was noted at right flank incision hernia patient.

Conclusions: We shared our early experience with preperitoneal hernia repair with mesh. They showed benefits at post operation hospitalization, wound pain and cosmetic to compare with open approach.

P002 - Abdominal Cavity and Abdominal Wall

Morgagni Hernia - Laparoscopic Approach

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Morgagni hernia develops after a congenital retrosternal diaphragmatic defect, a rare form of diaphragmatic hernia (1–3% of cases). In general, this pathology is diagnosed in children, and in adults it is frequently discovered in emergency.

Methods: We prospectively evaluated a series of 7 patients admitted to First Surgical Clinic, St. Spiridon Hospital, Iasi during 2011–2017.

Results: Out of 7 patients, 6 were operated, one refusing surgery but being followed periodically. Symptomatology was nonspecific in 5 cases that were discovered in the exploration of an associated pathology, either with cardiopulmonary symptoms of dyspnea or palpitations. In 2 cases, the clinical aspect suggested an occlusive syndrome (the herniated organ is usually the transverse colon). The laparoscopic approach was used in all cases, recording one conversion, due to the tight intrascale adherence of the herniated viscera (gastric, colon, epiploon). In 4 cases the surgical cure of hernia was performed by suture and in 2 cases with prosthesis: dual mesh in one case and polypropylene mesh in another case. We not registred morbidity and mean postoperative stay was 3.5 days (range 2–6 days).

Conclusions: Hernia Morgagni is a rare pathology. The most common is asymptomatic but in complicated cases it is a cause of acute surgical abdomen. Surgical treatment is indicated even for asymptomatic cases due to serious complications to which it may evolve. Laparoscopic approach is ideal, reduction of viscera in the abdomen is easy, herniar sac in general is not excised and the defect will be repaired depending on size by suturing or using a prosthesis.

P359 - Oesophageal and Oesophagogastric Junction Disorder

Percutaneous Laparoscopic Surgical Approach for Achalasia: Minimize Skin Trauma While Ensuring Ergonomics and Results

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Aim: In recent times, many efforts have been made to minimize the abdominal wall trauma in order to reduce postoperative pain and obtain a prompt return to daily activities, as well as improve cosmetic results of surgery. The progressive development of novel surgical devices has allowed the introduction of new minimally invasive surgical techniques and instruments. Criticism of the single incision laparoscopic surgery includes a modification of surgical technique, intraoperative conflict of instruments and increased incidence of wound-related complications as infections and incisional hernia; on the other side, peroral endoscopic myotomy has shown higher post-procedure gastro-esophageal reflux rate. In this study we propose a novel mini-invasive approach to perform a standard laparoscopic Heller's myotomy with Dor fundoplication in order to reduce the impact on the abdominal wall and reduce skin visible scars as well as maintain the correct surgical approach for achalasia.

Methods: We present our experience using MiniLap Percutaneous Surgical System® (Teleflex®) to perform a two-trocar laparoscopic percutaneous assisted esophageal Heller's myotomy with Dor fundoplication. Five patients suffering from Type II achalasia underwent surgery between November 2015 and June 2016. The proposed technique allows the replacement of three 5 mm trocars with three MiniLap percutaneous instruments of 2.3 mm diameter. These devices can be percutaneously inserted using an integrated needle tip, so no trocar is needed. After removing these instruments no stitches are required, but wound closure strips are used.

Results: After a minimum fifteen-months follow up, there was no recurrence of dysphagia in any of the patients treated. Median Eckardt's score was 1 (0–2), in range with ordinary performed laparoscopic Heller's myotomy. Postoperative analgesia was managed with acetaminophen, if required. The esthetic result was optimal as the 2.3 mm scars were nearly undetectable. No surgical site infections were recorded. The surgeons found the instruments comfortable and ergonomic and there was no need to change the surgical approach.

Conclusions: The use of percutaneous instruments was not inferior in terms of clinical outcomes as compared with standard technique, while improving cosmetic results and reducing trocar-related abdominal pain.

P360 - Oesophageal and Oesophagogastric Junction Disorder

Minimally Invasive Treatment of Patients with Esophageal Varices Bleeding

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Aims: The aim of our study was to decrease of mortality rates and improve the outcome of treatment in patients with esophageal varices bleeding.

Methods: The study is based on the prospective analysis of treatment results of 237 patients with esophageal varices bleeding, who were on inpatient treatment in the Vinnytsia regional center of the gastrointestinal bleeding in 2014–2017. Total number of men – 135 (56.96%), women – 102 (43.04%). The average age of patients was 57.0 ± 3.4 years. The source of bleeding was established during endoscopy. All patients received drug therapy – hemostatic, antisecretory, infusion, symptomatic. In 2014–2016 patients (group 1, $n = 195$) received just drug therapy. From the second half of 2016 we began to perform minimally invasive endoscopic surgical interventions such as ligation of bleeding esophageal varices (group 2, $n = 42$). After endoscopic band ligation reliable hemostasis was achieved in all cases. According to protocol and in the absence of contraindications to decrease portal pressure all patients received non-selective beta-blockers. Subsequently, to reduce portal hypertension and on purpose to prevent new varices emergence the splenic artery embolization was performed.

Results: In group 1 total number of men was 105 (53.8%), women – 90 (46.2%). The average age of patients was 56.0 ± 4.2 years. Using just drug therapy we have stopped bleeding in 152 (77.95%) cases. In all cases at the end of treatment we received improvement of clinical and laboratory indices. 43 patients (22.05%) were died. Duration of treatment was 10.2 ± 2.1 days.

In group 2 total number of men was 30 (71.4%), women – 12 (28.6%). The average age of patients was 54.0 ± 5.1 years. Performing of endoscopic band ligation and splenic artery embolization we have stopped bleeding in 36 (85.7%) cases. In all cases at the end of treatment we received improvement of clinical and laboratory indices. 6 patients (14.3%) were died. Duration of treatment was 6.2 ± 2.5 days.

Conclusion: Under the condition of esophageal varices bleeding treatment by performing of combination of endoscopic band ligation and splenic artery embolization in comparison with drug therapy we can see the improvement of patient's condition, decreasing of mortality and duration of treatment.

P361 - Oesophageal and Oesophagogastric Junction Disorder

Esophageal Leiomyoma: A Sixteen-Year Experience from A Single Tertiary Care Referral Center

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Background: Esophageal leiomyoma, although infrequent, is the most common benign intramural tumor of the esophagus. In about 50% of the cases, leiomyoma is asymptomatic and discovered incidentally. Minimally invasive enucleation is the treatment of choice but the surgical approach depends on tumor location. Aim of the study was to review our surgical experience in order to verify the safety and efficacy of minimally invasive enucleation.

Methods: A retrospective review over a 16-year period of patients who underwent surgical resection for esophageal leiomyoma was done. Demographic data, presenting symptoms, tumor location, tumor characteristics and histology, diagnostic procedures, and treatment modalities/outcomes were analyzed.

Results: Twenty-five patients with esophageal leiomyomas underwent surgical enucleation: 12 (48%) patients via laparoscopy and in 3 patients a Nissen fundoplication was added, in 9 patients a Toupet fundoplication and in 1 patient a Dor fundoplication. A prone thoracoscopy was performed in 12 patients (48%) and a hybrid endo-laparoscopic trans-gastric approach was performed in 1 (4%) patient with a plongeant tumor of the esophagogastric junction. Intraoperative endoscopy was routinely performed in order to identify landmarks and verify mucosal integrity. All patients underwent en-bloc enucleation without esophageal resection. Mean operative time was 151 ± 66.3 min. Mean tumor diameter was 5.4 ± 3.2 cm. A benign leiomyoma was diagnosed in all cases. No mucosal perforation occurred. The overall morbidity rate was 16%: there were 2 cases of pneumothorax treated with thoracic drainage, 1 case of subcutaneous emphysema and 1 case of pneumonia treated with antibiotics. Mortality rate was 0%. Mean hospital stay was 4.0 ± 1.8 days.

Conclusions: Minimally invasive enucleation is safe and effective for esophageal leiomyoma. En-bloc enucleation can be successfully achieved by a variety of surgical approaches. Routine intraoperative endoscopy may reduce the incidence of unrecognized mucosal injury.