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Exhibit Hall Videos

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V006

Robotic Roux-en-Y Hepaticojejunostomy for Delayed Hilar Stricture Following Laparoscopic Cholecystectomy

Kawtar S. Guenoun, Melissa Touadi, Moran Slavin, Iswanto Sucandy, Sharona Ross, Advent Health

63 y/o man presented to clinic with jaundice (Total Bilirubin was 22 mg/dL) after a complicated laparoscopic cholecystectomy for gangrenous cholecystitis. CT scan revealed a biloma within the gallbladder fossa, mild pneumobilia and, intrahepatic bile duct dilations. ERCP showed a hilar stricture which persisted after five ERCP with balloon dilations. The procedure started with drainage of intrahepatic subcapsular biloma. Endobiliary stents were removed. Debris and stones were removed from the bile duct using a Fogarty #3 via transcholedochal approach. An anterior Roux-en-Y hepaticojejunostomy anastomosis was performed. Patient did very well and was discharged home on POD 5.

V007

Robotic Hepatic Artery Infusion Pump Placement

Angela L Hill, MD; Meranda Scherer, RN; Darren R Cullinan, MD; Adeel S Khan, MD, MPH, FACS; Washington University in St. Louis

This video demonstrates robotic hepatic arterial pump placement in a patient with standard hepatic arterial anatomy. The patient is a 53-year-old male with unresectable bilobar metastatic rectal cancer. Surgical steps included suspension of the gallbladder to expose the porta hepatis, dissection of the hepatic artery lymph node, identification of the proper hepatic artery, and control of the gastroduodenal artery (GDA). Catheter securement within the GDA, just proximal to the hepatic artery, is also shown. Homogenous uptake of methylene blue within the liver on pump injection indicated good catheter placement. The patient was safely discharged on postoperative day one.

V008

Laparoscopic Transgastric Removal of a Gastroesophageal Junction Leiomyoma

Justin Philip, MD; Thadeus L Trus, MD; Sarah E Billmeier, MD, MPH; Dartmouth-Hitchcock

This is a 27 year old female with morbid obesity who had a 6 × 2 cm submucosal GE Junction mass that was found incidentally on EGD during work up of GERD prior to a planned bariatric surgery. The patient underwent an EUS/FNA which demonstrated a smooth muscle neoplasm consistent with a leiomyoma. This video demonstrates the key steps of performing a successful, safe trans-gastric resection of a benign GE Junction mass using hook cautery, blunt dissection and endoscopy with just three (3) 5 mm ports.

V009

Laparoscopic Transgastric Excision of Gastroesophageal Junction GIST

Samuel Klinker, MD¹; Katelyn Mellion, MD²; Kirk Arneson²; ¹Gundersen Medical Foundation; ²Gundersen Health System

A 69-year-old female presented to the emergency room with complaints of light headedness, syncope and melena. She underwent esophagogastroduodenoscopy which identified an ulcerated, submucosal based mass of the lesser curve of the stomach which was less than 1 cm from the gastroesophageal (GE) junction. Biopsy of the mass revealed a gastrointestinal stromal tumor (GIST). She had persistent gastrointestinal bleeding, so she was taken for a laparoscopic trans-gastric excision of the GE junction GIST.

V010**Minimally Invasive Repair of a Perineal Hernia**

Shruthi Nammalwar, MD; Desmond Huynh, MD; Shirin Towfigh, MD, FACS; Cedars Sinai Medical Center

Our patient is a 67 year old female with a primary perineal hernia who was successfully treated by robotic transabdominal-preperitoneal repair. Reliable diagnosis requires a detailed history with high suspicion for perineal hernia queried in patients with unexplained lower quadrant and perineal pain. Dynamic imaging with valsalva can help produce occult perineal hernias. Repair requires understanding perineal anatomy. Robotic transabdominal preperitoneal (rTAPP) repair can be primary or with mesh depending on the size and significance of the herniation.

V011**How We Do It: Zenker's Per Oral Diverticulectomy (Z-POEM) with Impedance Planimetry**

Simon Y Che, MD¹; Julia R Amundson, MD, MPH²; Stephanie Joseph, MD, MPH³; Shun Ishii, MD⁴; Vanessa N Vandruff, MD²; Christopher J Zimmermann, MD¹; Herbert M Hedberg, MD¹; Michael B Ujiki, MD¹; ¹NorthShore University HealthSystem; ²University of Chicago; ³Wayne State University; ⁴Kyorin University School of Medicine

Surgical management of Zenker's Diverticulum has undergone many iterations in management. Most recently, flexible endoscopic methods have adopted the technique of performing a myotomy through a submucosal tunnel. We display our technique for performing per oral endoscopic myotomy for Zenker's Diverticulum (Z-POEM) and how we obtain impedance planimetry measurements which may be helpful in determining adequacy of myotomy.

V012**Laparoscopic Bochdalek Hernia Repair**

Abdulaziz Karam Ali; Safiya AlMasroori; Sebastian Demyttenaere; McGill University

Congenital diaphragmatic hernias are rarely seen in adults which makes the diagnosis challenging. In this video, we demonstrate our experience repairing a Bochdalek hernia laparoscopically. The patient is a healthy 62 year old female who presented with acute abdominal pain and obstruction. Relevant CT findings are reviewed. We demonstrate the somewhat challenging reduction of the stomach, small bowel, colon, spleen and tail of the pancreas. The video then demonstrates the repair of this hernia and summarizes important key concepts. In 3 and 6 month follow-up, the patient has recovered uneventfully and is doing great.

V013**Robotic Transcystic Common Bile Duct Exploration**

Anastasya Chuchulo, MD; Ali Abubaker, MD, FACS; Detroit Medical Center

Laparoscopic single stage management for choledocholithiasis has been shown to be superior to two stage procedures (ERCP followed by cholecystectomy) in terms of hospital stay, cost and operative time despite being less frequently performed. Further studies show that transcystic laparoscopic common bile duct (CBD) exploration is safer and more cost effective than laparoscopic choledochotomy CBD exploration. We present a video describing a single stage robotic transcystic CBD exploration with the use of a disposable ureteroscope, safely and effectively removing CBD stones at the same procedure as a minimally invasive cholecystectomy.

V015**Collateral Damage in the COVID Era? Repair of Post-COVID-19 Diaphragmatic Eventration and Pexy of Intermittent Gastric Volvulus**

Voranaddha Vacharathit, MD; Padet Tanangterapong, MD; Sopark Manasayakorn, MD, PhD; Pattharasai Kachornvitaya, MD; Chayatat Sirinawin, MD; Chulalongkorn Memorial Hospital

COVID-19 is a contributor to diaphragmatic dysfunction in up to 10% of patients after severe COVID. Diaphragmatic eventration can be acquired from viral infection, or congenital. Eventration-associated gastric volvulus is rare and usually organoaxial. We present a laparoscopic transabdominal diaphragmatic resection and anterior gastropexy for a symptomatic eventration with organoaxial volvulus found in a post-COVID-19 patient. Classically, diaphragmatic plication is the gold-standard for eventration repair, but stapled resection is safe and feasible with long-term studies needed. As far as we know, this is the first report of a post-COVID-19 eventration-volvulus repair. Preoperative workup and intraoperative technical considerations are discussed.

V016**Robotic Bilateral Polycystic Nephrectomy with Simultaneous Kidney Transplant: An Innovative Approach**

Massimo Arcerito, MD; Raphael P Meier, MD; Amber Carrier, PHD, MD; Anna Axentiev, MD; Daniel Maluf, MD; Chandra Bhati, MD; University of Maryland. Division of Transplant. Department of Surgery

Robotic bilateral nephrectomy for polycystic kidney disease (PKD) has been previously described. We present an innovative technique with a combined bilateral polycystic nephrectomy with simultaneous kidney transplant. A 52 yr old male with PKD on dialysis was evaluated. He underwent successfully the combined procedure. The robotic kidney transplant technique is described in its steps including the venous, artery, ureteral anastomoses. The patient was discharged on postoperative day 3, making physiologic urines. Robotic bilateral nephrectomy with simultaneous kidney transplant is an achievable procedure as long as open surgical steps are applied minimizing the ischemic time and achieving successful allograft reperfusion technique.

V017**Robotic Anterior Resection with Intracorporeal Anastomosis**

Hassan Masoudpoor, MD; Ryan Moore, MD; Howard Ross, MD; Steven Lee-Kong, MD; Hackensack University Medical Center, Hackensack Meridian School of Medicine

This video demonstrates techniques in performing a robotic anterior resection with intracorporeal anastomosis for cancer. The patient is a 48 year-old man who originally presented for a routine screening colonoscopy. A mass was noted in the rectosigmoid colon, and pathology confirmed invasive adenocarcinoma. A traditional medial to lateral approach was performed, as well as intra-corporeal bowel division. Anastomosis was achieved using a 31 mm trans-anal EEA stapling device. The patient was discharged the day after surgery and made an uneventful recovery. All margins were negative and 20 lymph nodes were retrieved.

V025**Endoscopic Repair of an Esophago-Gastric Fistula Following a Nissen Fundoplication Using an Endoscopic Helical Tacking Device**

Lauren McTaggart; Salvatore Docimo; University of South Florida

We present a 57 year-old female with a history of laparoscopic hiatal hernia repair with Nissen fundoplication presenting with gastroesophageal reflux. She had an esophagram and upper endoscopy that showed an esophagogastric fistula. Our diagnostic upper endoscopy confirmed a fistula between the lower esophagus and fundus. On therapeutic upper endoscopy, the fistula track was cauterized with an argon plasma coagulation catheter and closed with an endoscopic helical tacking system to close both the esophageal and gastric fistula openings. Post-operatively, the patient had symptomatic improvement with resolution of the fistula noted on follow-up esophagram.

V026**Management of a Splenic Abscess, Complicated Pleural Effusion, and Stent Migration After Laparoscopic Sleeve Gastrectomy Complicated by Leak**

Samir Narula, MD; Brian F Gilchrist, MD; Pratibha Vemulapalli, MD; The Brooklyn Hospital Center

We present an 18-year-old morbidly obese male who underwent laparoscopic sleeve gastrectomy complicated by a delayed leak. We endoscopically placed a gastroesophageal stent to control the leak. He did not improve clinically, and imaging showed an enlarging splenic abscess which was drained percutaneously and subsequently removed. He re-presented with dyspnea and was found to have a complicated left pleural effusion and a worsening splenic abscess; both were drained percutaneously with significant improvement. He re-presented with acute abdominal pain; endoscopy showed migration of the stent which had impacted in the antrum, the leak had healed, and the stent was removed.

V027**Single Port Robotic Right Colectomy: Standardized Steps and Technique for Mastery of a New Technology**

Tian Y Sun; Taylor P Ikner; Emily Kunkel; Henry P Schoonyoung; Deborah S Keller; John H Marks; Lankenau Medical Center

Standardization of operative procedures is critical for ensuring the highest efficiency and surgical quality across all surgical platforms. Using 9 standard steps for a right colectomy has also helped surgeons in our training program and practice ascend the learning curve towards mastery. The single port robot is a new platform being used on trial in our practice. As early adapters, applying the standard steps has facilitated safe integration of this innovative technology into practice. Here, we present a single port robotic right colectomy.

V028**Transabdominal Scrotal Hydrocelectomy: a Robotic Approach**

Makenna Marty, MD; David Lourié, MD; Huntington Hospital

We present an alternative to trans-scrotal hydrocelectomy with the case of a 71-year-old male with bilateral incarcerated inguinal hernias. Physical exam and CT imaging were both indicative of a large distal noncommunicating 10.5 cm scrotal hydrocele. Using a robotic approach, the attenuated posterior wall of the inguinal canal was opened through the hernia defect, allowing access to the distal scrotal hydrocele transabdominally. Complete excision of the hydrocele sac was achieved. No drain was placed. With robotic expertise, detailed anatomic knowledge, and an appropriately selected patient, we conclude this approach is an appropriate technique for concurrent hydrocelectomy with hernia repair.

V029**Laparoscopic/Endoscopic Magnetic Side-to-Side SADI-S (Single Anastomosis Duodeno-Ileostomy with Sleeve Gastrectomy)**

Michel Gagner, MD, FRCSC, FACS1; David Abuladze, MD2; Levan Koiava, MD2; Maxime Lapointe-Gagner, BSc1; 1Westmount Square Surgical Center; 2Innova Medical Center, Tbilisi, Georgia

A 48 y.o. female patient with a BMI of 37.6 kg/m², presenting comorbidities including Hypertension, Dyslipidemia, and Non-Alcoholic Fatty Liver Disease underwent a Laparoscopic/Endoscopic Magnetic Side-to-side Single Anastomosis Duodeno-Ileostomy with Sleeve Gastrectomy. A side-to-side duodeno-ileostomy is accomplished using linear magnets delivered both by flexible endoscopy, while laparoscopic assistance provide adequate ileum measurements. The operation ends with a sleeve gastrectomy which includes staple line reinforcements. The delayed compression anastomosis may decrease risk of bleeding and leaks, as after 4 weeks magnets pass. The anastomosis is reversible, allows partial passage in the natural duodenum for ERCP if needed, and absorption of minerals and vitamins.

V030**Ureter Identification in Complex Scenarios**

Daniel Aillaud De Uriarte¹; Andrea Hernandez Moreno²; Diego C Marines Copado³; Victor G Peña, MD⁴; ¹Universidad de las Americas Puebla, School of Medicine; ²Universidad Anahuac Puebla, School of Medicine; ³Houston Methodist Willowbrook; ⁴Universidad de Monterrey, School of Medicine

Through this video, it is exposed why the ureters are the most commonly injured retroperitoneal structure in colorectal surgery.

Standardized technique is required during colon resection, including identification of the ureters. During this portion of the procedure, the sigmoid colon is mobilized medial-to-lateral, guiding the course of the ureter below vessels and above psoas tendon.

Dissection may be challenging for newly-trained surgeons owing to their similarity to these structures. Strategies and suggestions are shared for making it less complicated for procedures with higher risk of ureteral injury associated with significant mortality and morbidity.

V031**Robotic Transabdominal Preperitoneal Repair of Direct Inguinal Hernias: Incarcerated Bowel and Bladder**

Claire B Rosen, MD; Jenny M Shao, MD; Hospital of the University of Pennsylvania

Inguinal hernias are common and can significantly affect quality of life. This video demonstrates a robotic transabdominal preperitoneal repair of bilateral direct inguinal hernias in a patient with incarcerated bowel and bladder. Both defects were closed primarily prior to mesh placement to sit a shelf for the mesh to prevent mesh evertation. Mesh was secured using sutures and tissue glue. After the procedure, the patient recovered well, with no complications on short-term follow up. The robotic approach to bilateral inguinal hernias with incarcerated bowel and bladder is feasible with favorable outcomes and short recovery time.

V032**TAMIS Resection of Early Rectal Cancer Using Advanced Articulating Instrument**

Daniel Farinas Lugo, MD; Liam Devane, MD; Matthew Albert, MD; Advent Health

A 57 year old male presented with an incidental rectal cancer identified on screening colonoscopy. Biopsy confirmed rectal adenocarcinoma and a staging MRI revealed a T1/T2 N0 tumor. Rigid proctoscopy demonstrated a 2.5 cm ulcerated lesion in the left posterior mid rectum at 9 cm. He underwent transanal minimally invasive surgical (TAMIS) full thickness excision using an articulating laparoscopic dissector with electrocautery. This articulating instrument facilitated accurate dissection in the confined space of the rectum. The defect was closed with a running V-lock suture. Final pathology revealed pT1sm2 rectal adenocarcinoma with negative margins.

V033**Intravesical Foreign Body: Lessons Learned from Failed Endoscopic Colovesical Fistula Management**

Victoria Rendell, MD; Parth Sharma, MD; John Knoedler, MD; Eric Pauli, MD; Penn State Health Milton S. Hershey Medical Center

Colovesical fistulas are most frequently managed surgically; however, endoscopic management has increasingly been reported. This video presents an endoscopic evaluation of a colovesical fistula that recurred after prior minimally invasive deployment of a vascular metal plug into the fistula tract. The plug dislodged and accumulated bladder stone material. With our team's combined endoscopy and cystoscopy evaluation, the complex fistula anatomy was clearly defined, and the plug was removed with holium laser lithotripsy. We demonstrate the importance of following key principles of fistula management and highlight the helpful role of multidisciplinary endoscopic evaluation in the management of colovesical fistulas.

V034**Surgical Management of Gastroparesis after Roux-en-Y Gastric Bypass**

Karl Hage¹; Ishna Sharma¹; Marita Salame¹; Travis McKenzie¹; Benjamin Clapp²; Barham Abu Dayyeh³; Omar M Ghanem¹; ¹Department of Surgery, Mayo Clinic. Rochester, MN; ²Department of Surgery, Texas Tech HSC Paul Foster School of Medicine, El Paso, TX; ³Division of Gastroenterology and Hepatology, Mayo Clinic, Rochester, MN

We describe the case of a 60-year-old female with a history of Roux-en-Y gastric diversion for recurrent ulcers who presented due to a 60-pounds weight loss and continuous vomiting. The diagnosis of gastroparesis was made after a thorough workup identified a large pouch with delayed gastric emptying. She was treated with partial gastrectomy with Roux-en-Y reconstruction. A smaller pouch was constructed with the reestablishment of a new gastro-jejunostomy. Patient follow-up was favorable without any post-operative complications. In conclusion, the reconstructed pouch in patients with Roux-en-Y gastric diversion has to be the smallest possible in order to avoid an atonic stomach.

V035**Unexpected Finding in the Common Bile Duct**

Juan S Barajas-Gamboa, MD; Alia Alhareb, MD; Yaqeen Qudah, MD; Gabriel Diaz del Gobbo, MD; Mohammed Abdallah, MD; Carlos Abril, MD; Ricard Corcelles, MD; John Rodriguez, MD; Matthew Kroh, MD; Javed Raza, MD; Cleveland Clinic Abu Dhabi

A 57-year-old female was presented with progressive epigastric pain. US showed clumps of sandstones, bile sludges without acute cholecystitis and progressive dilated common bile duct (CBD) without intrahepatic-duct dilatation. MRI did not detect stones. Laparoscopic cholecystectomy was performed with intraoperative cholangiogram (IC). IC revealed an opacity in the lower end of the CBD. A choledochoscopy was performed to take biopsies of the tumor, which reported an adenoma with high-grade dysplasia. Posteriorly, the patient underwent pancreaticoduodenectomy. Pathology reported a tubulovillous adenoma involving the ampulla of Vater and distal CBD, but no invasive cancer. Patient is under follow-up with no additional treatments.

V036**Complication Repair: Leak Following Sleeve Gastrectomy**

Maher Khrais, Dr; Al-Kindi Hospital

28-year female who had a re-sleeve 1 week prior to her presentation. They reoperated and drains were inserted without repairing the leak. She presented with intra-abdominal sepsis. Leak site identified on the GE junction with dye test. Roux limb created and anastomosed to the

site of leak. Dye test then done to ensure the site of leak is completely diverted to the small bowel. gastrojejunal bypass was then done to decrease the intragastric pressure. Lastly, jejunojunal anastomosis done to direct the bile away from the gastrojejunostomy. Patient recovered well and back at work on her 1 month follow up.

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