

Video Session Abstracts

V-101

COMPLICATION-CHRONIC SLEEVE LEAK AND RETAINED STENT

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Background: Sleeve gastrectomy is emerging as a popular option in bariatric surgery. Sleeve leak is a known complication of this procedure and many propose the use of endoluminal stents in the management of sleeve leaks. Stents also carry their own set of risks and complications.

Methods: This is a case of a patient who underwent a sleeve gastrectomy and developed a postoperative leak. An attempted to manage this leak with endoluminal stenting was unsuccessful and the patient developed a chronic fistula. In addition, the stents that were placed could not be retrieved due to dense mucosal in-growth.

Results: This video presentation shows a combination of a laparoscopic and endoscopic approach in treating this particular patient with a chronic leak and retained stents.

Conclusion: Covered stents can be used in treating sleeve leaks, however, they also have risks and complications. Mucosal in-growth is a complication of stents and may make stent retrieval a challenge. The combined laparoscopic and endoscopic approach of stent retrieval is one method in approaching this difficult problem.

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LAPAROSCOPIC MANAGEMENT OF ACUTE OBSTRUCTION DUE TO INTRALUMINAL THROMBUS AFTER ROUX-EN-Y GASTRIC BYPASS

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Background: Small bowel obstruction after laparoscopic Roux-en-Y gastric bypass (LRYGB) has been reported with an incidence of 0.6 to 3.1%. In less than ten cases the obstruction was due to an intraluminal thrombus, requiring exploratory laparotomy. To our knowledge this is the first report of laparoscopic management of an intraluminal blood clot causing acute bowel obstruction after LRYGB. **Methods:** A 38-year-old woman underwent LRYGB. The postoperative contrast evaluation revealed no evidence of leak, but hold up of contrast within the Roux limb. After receiving fractionated heparin, she developed emesis, abdominal pain and tachycardia. The CT scan demonstrated bowel obstruction, likely secondary to an intraluminal thrombus at the jejunojejunostomy. Between the options of percutaneous gastric remnant with nasogastric tube decompressions, and re-exploration, the operative approach was chosen.

Results: She underwent urgent laparoscopic gastrostomy tube placement to decompress the gastric remnant, followed by needle decompression of the proximal Roux limb to allow safe bowel manipulation. Finally, the obstruction was relieved by an intraluminal suction thrombectomy of the common channel via a longitudinal enterotomy. The repeat swallow test demonstrated normal flow of contrast. She was discharged home on postoperative day 8 after tolerated adequate oral intake, without further complications.

Conclusion: Although rarely, intraluminal blood clots can cause acute early postoperative bowel obstruction after LRYGB. Laparoscopic thrombus evacuation can be safely accomplished. Whenever patency of the jejunostomy is in question, anastomotic revision is necessary.

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LAPAROSCOPIC MANAGEMENT OF ANASTOMOTIC BLEEDING AFTER ROUX-EN-Y GASTRIC BYPASS

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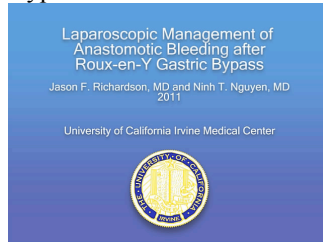
Background: A video demonstration of the laparoscopic and endoscopic management of

postoperative anastomotic bleeding within hours after Roux-en-Y gastric bypass.

Methods: Small bowel decompression, endoscopic evaluation, and oversewing of the staple lines are featured in this video.

Results: This video documents that procedure.

Conclusion: Laparoscopic Management of Anastomotic Bleeding after Roux-en-Y Gastric Bypass.



Laparoscopic Management of Anastomotic Bleeding after Roux-en-Y Gastric Bypass

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COMBINED ENDOSCOPIC/LAPAROSCOPIC REPAIR OF GASTROGASTRIC FISTULA AND BAND EROSION COMPLICATING BANDED ROUX-EN-Y GASTRIC BYPASS

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Background: A 59 year old female presents with nausea and emesis and found to have a gastrogastic fistula and an eroded band as a complication of an open banded gastric bypass performed to revise her open jejunoileal bypass. She undergoes a complex revisional combined laparoscopic/endoscopic excision of the gastrogastic fistula and removal of eroded band with resolution of symptoms post-operatively

Methods: Video

Results: Video

Conclusion: Video

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LAPAROSCOPIC INTRAGASTRIC REMOVAL OF ERODED GASTRIC BANDING USING A GEL PORT

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Background: Eroded gastric bands may be removed endoscopically or laparoscopically; both having their advantages and disadvantages. This video demonstrates a variation of the laparoscopic technique

Methods: An edited video

Results: By securing a laparoscopic gel port intragastrically at the body of the stomach, the stomach can be insufflated and the eroded band can be safely removed under direct vision. This method avoids dissecting the inflammatory capsule that is associated with the gastric band

Conclusion: A laparoscopic intragastric gel port allows for insufflation of the stomach and safe removal of an eroded gastric band; thereby avoiding dissection of the inflammatory capsule

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TRANSORAL ENDOSCOPIC SURGERY TO UNBUCKLE AND REMOVE LAPAROSCOPIC ADJUSTABLE GASTRIC BAND

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Background: While laparoscopic adjustable gastric banding (Lap Band) is a well-accepted option for weight loss, some patients will have complications. One such complication is band erosion. Various techniques have been described to remove the band. Herein we demonstrate a technique useful for treatment of band erosion by endoscopically unbuckling and removing the band transorally.

Methods: A patient developed a band erosion a year after a successful Lap Band placement (AP Large Lap Band). He had lost over 100 pounds. He was initially diagnosed with a port site infection. Serial endoscopies demonstrated erosions of 60% to about 90%. He was taken to the operating room for endoscopic versus laparoscopic removal. During surgery, the port incision was opened up and the tubing was cut subcutaneously. Endoscopy was used to unbuckle the band and remove the band transorally.

Results: Postoperatively, the patient did well. A radiological study demonstrated no leakage. He was discharged on the second postoperative day. He is doing well and still deciding on another weight loss surgery option.

Conclusion: Simple endoscopy can be utilized to treat an eroded band without sophisticated instruments. This technique should be attempted to treat eroded bands.

ONE STAGE REMOVAL OF A SLIPPED GASTRIC BAND AND REPAIR OF A LARGE PARAOESOPHAGEAL HERNIA FOLLOWED BY REVISION TO A GASTRIC BYPASS. WAS IT ALL TOO MUCH AT THE SAME TIME?

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Background: A case of a patient with a gastric band, severe GORD and unsatisfactory weight loss. Radiological investigations confirmed a large paraoesophageal hernia with a gastric band lying in an abnormal position.

Methods: Laparoscopy was performed. The stomach with the malpositioned gastric band were herniated into the chest through a large defect. The stomach was reduced, the band removed and the hernia defect repaired using biological mesh. This was followed by revision to a Roux-en-Y gastric bypass. All was performed in the same operative session.

Results: Patient went on to develop signs of sepsis in the early postoperative period and radiological investigations confirmed a leak. Relaparoscopy was performed and a leak was found to be not from the anastomotic line but from the upper staple line of the vertical gastric pouch adjacent to the site of the previous gastric band. This was washed out, resutured and then drained. Postoperatively patient needed CT guided drainage of another collection. She recovered slowly after that and was discharged.

Conclusion: In this case repairing the large paraoesophageal hernia and removing the band for management of the GORD at one stage and then performing the gastric bypass at a later stage may have been a safer option. Staging a difficult and lengthy complex bariatric procedure maybe a safer alternative.

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REVISION OF GASTRIC BAND TO SLEEVE GASTRECTOMY, THEN SLEEVE GASTRECTOMY TO GASTRIC BYPASS IN A MATTER OF ONE WEEK

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Background: A case of a patient who had a gastric band placed 4 years earlier and opted for an elective revision to sleeve gastrectomy after failing to achieve significant weight loss with the gastric band.

Methods: Laparoscopic removal of the gastric band followed by revision to a sleeve gastrectomy in the same operative session.

Results: Patient went on to develop complete intolerance to oral intake the following day. Endoscopy was done but there was marked stricturing a short distance after the oesophagastric junction. Laparoscopy was done and the stricture was found to be at the site of the pseudocapsule from the previous gastric band and revision into a Roux-en-Y gastric bypass was done. Patient had an uneventful post-operative period and was tolerant to oral fluids.

Conclusion: Patients with long standing gastric bands tend to form a firm pseudocapsule around the band. Should revisional surgery be attempted, this pseudocapsule should be carefully dissected to avoid potential stricturing complications.

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FIRST EXPERIENCE WITH LAPAROSCOPIC CONVERSION OF GASTRIC PPLICATION TO SLEEVE GASTRECTOMY

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Background: We present a case of gastric plication successfully converted laparoscopically to sleeve gastrectomy. A 35 year old lady with initial BMI of 40 with type 2 diabetes mellitus and hypertension underwent laparoscopic gastric banding 7 years ago. She lost 10 kg over that period of time without significant improvement of comorbidities. Six months prior to current presentation she underwent laparoscopic gastric band removal and gastric greater curvature plication with 2 rows of running non absorbable suture. Subsequently she lost 8 kg of weight over 6 months.

Methods: Laparoscopic exploration revealed dilated gastric pouch with gastro-splenic ligament adherent to the plication line and dense adhesion of gastric cardia with liver resultant from previous gastric banding. The plicated greater curvature was unfolded by sharp dissection of suture line. Dense adhesions were present at the site of suture line, but underlying serosa was intact. Sleeve gastrectomy was performed with sequential firing of green cartridges 4.1mm over buttressed material from 4cm above the pylorus up to

the angle of His over 36F bougie. The staple line was reinforced at overlapping points with PDS 3.0 interrupted sutures.

Results: Postoperative period was uneventful and patient was discharged on second postoperative day tolerating liquid diet. In follow up period of 2 months patient lost 12kg. Further gross inspection of the specimen and comparative histopathology of plicated stomach wall with non plicated one showed significant thickening and fibrosis of the greater curvature due to suture line reaction.

Conclusion: Therefore we recommend everting the greater curvature prior to firing the stapler. Even though long term data regarding efficacy of gastric plication are lacking, convertibility of any bariatric procedure remains an advantage, even though challenging.

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CANDY CANE ROUX SYNDROME: PRESENTATION AND SURGICAL TREATMENT

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Background: Candy cane Roux syndrome is a largely unrecognized complication of laparoscopic Roux-en-Y gastric bypass (LRYGB) caused by a redundant proximal Roux limb tip. Presenting symptoms include epigastric pain, nausea, and vomiting. Symptom resolution has been reported with resection of the redundant portion of the proximal Roux limb tip.

Methods: We present the case of a patient treated for candy cane Roux syndrome. The video will review the presentation and demonstrate the technical aspects of surgical treatment for candy cane Roux syndrome.

Results: A 63-year-old woman who underwent LRYGB 7 years prior presented with reflux symptoms for which she had taken proton pump inhibitors (PPI) for 5 years. She noted a 13lb weight regain. An upper gastrointestinal series was performed for anatomical evaluation and demonstrated a lengthened blind tip of the Roux limb. We suspected the patient was stretching her blind tip and using it as a neo-pouch and food stagnation was causing reflux symptoms. The patient was taken to the operating room for resection of the

redundant portion of the candy cane limb. The patient reported symptom improvement and was able to discontinue PPI postoperatively. She lost 17lbs, surpassing her plateau weight by 4lbs.

Conclusion: Complications involving the proximal candy cane Roux limb can occur early or late. Early complications are likely due to technical error. However, there may be a rare set of patients that begin to use the candy cane limb as a neo-pouch. Resection and re-education regarding maladaptive eating behaviors may be beneficial in these patients.

V-111

SYMPTOMATIC HIATAL HERNIA AFTER LAPAROSCOPIC ROUX EN Y GASTRIC BYPASS

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Background: One of the co-morbid conditions associated with morbid obesity is gastroesophageal reflux disease (GERD). Laparoscopic Roux en Y gastric bypass (LRYGB) has been shown to be highly effective in the improvement or elimination of GERD symptoms postoperatively. Recurrence or new onset of GERD after successful weight loss with LRYGB may indicate the presence of a hiatal hernia. This report summarizes the diagnostic and therapeutic approach to these patients.

Methods: A retrospective analysis of 5 patients with either new onset or recurrence of GERD after successful weight loss following LRYGB was undertaken to determine the diagnostic and therapeutic approach to this problem.

Results: Three of the five patients had a hiatal hernia diagnosed by either or both upper endoscopy (EGD) or upper gastrointestinal series (UGI) or both. Two did not. All five patients had significant hiatal hernias, ranging from 4-6 cm in size containing all or part of the gastric pouch, identified during diagnostic laparoscopy. Reduction and crural repair led to complete resolution of GERD symptoms in all five patients.

Conclusion: Postoperative LRYGB patients in whom GERD symptoms were initially relieved and then return, or have new onset GERD after weight loss should be evaluated by diagnostic laparoscopy for the presence of a hiatal hernia. Reduction and crural repair of hiatal hernias in post LRYGB patients with GERD is highly effective in relieving their symptoms.

LAPAROSCOPIC SUTURE PPLICATION OF AN ENLARGED GASTROJEJUNOSTOMY AFTER GASTRIC BYPASS SURGERY

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Background: The purpose of this study is to determine if laparoscopic suture plication of an enlarged gastrojejunostomy with endoscopic guidance is a feasible and effective surgical option for the gastric bypass patient who has regained weight due to a dilated gastric stoma.

Methods: After obtaining IRB approval, a pilot study of bariatric patients who has recidivism of their morbid obesity after roux-en-Y gastric bypass surgery were selected to undergo laparoscopic suture plication of their enlarged gastrojejunostomy. They were evaluated preoperatively by obtaining a nutrition consult, upper gastrointestinal contrast study and upper endoscopy. Patients who meet the inclusion criteria then underwent laparoscopic suture plication on the anterior surfaces of the anastomosis. Seromuscular horizontal mattress sutures were placed on the gastric side of the anastomosis to avoid entering the lumen. The anastomosis was evaluated endoscopically intra-operatively to precisely recreate an appropriately sized gastrojejunostomy lumen.

Results: The procedure was performed in three patients with no intra-operative or post-operative complications. Each patient has a reduction in gastrojejunostomy lumen area and reported weight loss and good satiety with meals after short-term follow-up.

Conclusion: Laparoscopic plication of an enlarged gastrojejunostomy with endoscopic guidance is both safe and effective at reducing the gastric stoma size. This procedure can reliably reduce the diameter of the gastric stoma and can be tailored to precisely recreate an appropriately sized lumen. Long-term follow up will determine the extent of weight loss and clinical benefit in the bariatric patient who has regained weight secondary to an enlarged gastrojejunostomy.

V-113**REVISION OF BILLROTH II GASTRECTOMY TO ROUX-EN-Y GASTRIC BYPASS FOR MORBID OBESITY**

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Background: A case of a morbidly obese male patient with multiple obesity comorbidities with a past surgical history of previous elective surgery for management of peptic ulcer disease. The type and nature of the surgery were not known.

Methods: After confirming through radiological investigations and endoscopy that the type of gastrectomy is a Billroth II gastrectomy, exploratory laparotomy was undertaken first to identify the anatomy and confirm the type of gastrectomy and then to convert to a Roux-en-Y gastric bypass.

Results: Uneventful operation with an uneventful post-operative period. 5 months postoperative patient achieved a weight loss of 43 kg which equates to 30 % of the total body weight in addition to improvement of the comorbidities.

Conclusion: Conversion of Billroth II gastrectomy to a Roux-en-Y gastric bypass in a morbidly obese patient has shown in this case to be a valid option for the management of morbid obesity and its associated comorbidities with a satisfactory short term outcome.

V-114**LAPAROSCOPIC CONVERSION OF TRANSORAL GASTROPLASTY (TOGA) TO GASTRIC BYPASS**

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Background: This video abstract shows the laparoscopic conversion of a TOGA to a gastric bypass. Our patient is a 36 year-old female with a history of morbid obesity (BMI=47) without obesity related co-morbidities, who previously underwent a TOGA. After 1 year she had significant weight regain and loss of restriction, thus laparoscopic conversion to a gastric bypass was offered.

Methods: After bluntly dissecting the angle of His and performing a perigastric dissection of the lesser curve in order to access the lesser sac, we began stapling our gastric pouch. We aligned our endo-GIA staple fires with the anterior TOGA staple line but were lateral to the posterior staple line. This resulted in venous congestion and ischemia of the pouch. After passing a 21mm Or-vil anvil, we imbricated the ischemic portion of the pouch with interrupted 2-0 silk sutures. A standard roux-en-y gastric bypass was then performed with a 120cm roux limb.

Results: She had an uncomplicated postoperative course. After a normal upper GI was obtained on

postoperative day 2, she was advanced per our protocol and was discharged to home on postoperative day 3. At her two early postoperative visits she was losing weight and had excellent restriction.

Conclusion: Laparoscopic conversion of TOGA to gastric bypass is technically feasible, but care must be taken to align both the anterior and posterior staple lines during pouch formation in order to avoid pouch ischemia.

V-115

SLEEVE GASTRECTOMY WITH ANTERIOR PARTIAL FUNDOPLICATION

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Background: Laparoscopic sleeve gastrectomy is emerging as an attractive option in weight loss surgery. Short term results show weight loss and comorbidity resolution approaching results seen with laparoscopic Roux-en-Y gastric bypass. However, while gastric bypass is known to improve reflux symptoms it is seen that reflux symptoms persist or even develop in sleeve gastrectomy patients. The cause of these symptoms is likely multifactorial but may be due the altered anatomy at the angle of HIS leaving an incomplete anti-reflux mechanism subject to the higher intragastric pressures of the narrow tube.

Methods: We demonstrate the incorporation of a partial fundoplication in patients undergoing sleeve gastrectomy. When stapling to create the sleeve, a wedge of fundus is intentionally retained at the most cephalad extent of the stomach. This wedge can then be used in a partial fundoplication to create anterior augmentation at the gastroesophageal junction.

Results: We identified 6 patients seeking sleeve gastrectomy for weight loss. All 6 patients had documented pre-operative reflux symptoms. Follow-up ranges from 1 to 7 months. There were no readmissions and no mortalities. Four of six patients remain off medication and are symptom free. Two patients remain on their pre-operative medication in the early post-operative period and deny reflux symptoms.

Conclusion: Anterior fundoplication can be performed with a sleeve gastrectomy in the hope of reducing the severity, need for medications, and the future development of reflux after sleeve gastrectomy. If this proves to be effective, it may expand the applicability of sleeve gastrectomy.

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SINGLE INCISION SLEEVE GASTRECTOMY WITH SIMULTANEOUS HIATAL HERNIA REPAIR

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Background: Several authors have demonstrated the safety profile of single incision sleeve gastrectomy. However, the presence of concomitant hiatus hernia requires simultaneous repair. Concern has been raised about satisfactory crural repair with the single-incision approach. Herein, we present a case of Single Incision Sleeve Gastrectomy with simultaneous hiatal hernia repair.

Methods: A 49-year-old female was referred from her primary care physician for evaluation for surgical treatment for morbid obesity. Patient had 35-year history of obesity and failed several attempts of medically supervised weight loss. Her body mass index was 48. Her past medical history was significant for hypertension, osteoarthritis, degenerative joint disease, asthma and gastroesophageal reflux disease (GERD). Single incision Sleeve gastrectomy with hiatal hernia repair was performed. Primary crura closure was performed.

Results: Patient underwent a single incision sleeve gastrectomy hiatal hernia repair with posterior crura closure, through a 2.5 cm umbilical incision. Total operative time was 107 minutes, estimated blood loss was minimal. Hospital stay was 2 days. At 3 months follow-up patient did not complain of any GERD symptoms.

Conclusion: In selected patients, single incision sleeve gastrectomy with simultaneous hiatal hernia repair can be safely performed. However, single incision surgery should not preclude satisfactory repair of hiatal hernia when needed.

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SINGLE INCISION PLACEMENT OF A LAPAROSCOPIC ADJUSTABLE GASTRIC BAND OVER BYPASS

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Background: The patient is a 65yo female s/p gastric bypass 5 years ago with weight regain and current weight of 188 pounds with a BMI of 32. Despite satisfactory behavior patterns she experienced recurrent comorbid conditions as listed here.

Methods: This video demonstrates the technical aspects of single incision banding of a gastric bypass.

Results: This video demonstrates safe single incision placement of an adjustable gastric band over a roux-en-y gastric bypass.

Conclusion: Single Incision placement of an adjustable gastric band over bypass is a safe and feasible procedure.

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A “SLICK TRICK” FOR REPOSITIONING ADJUSTABLE GASTRIC BANDS AFTER SLIPPAGE

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Background: Despite improved techniques, gastric slippage remains a concern. Moderate to severe degrees of gastric slippage may necessitate reoperation for repositioning or removal of the band.

Methods: A 41 year old male with a history of a Realize C adjustable gastric band placed 2 years prior, presents with a 2 day history of nausea and vomiting. He lost 70% of his excess weight. An upper GI confirmed a slipped band. As the patient was successful with the band, we decided to reposition it. Initially, the band was cleaned of all adhesions. The remaining anterior gastric plication was divided. The key portion of the procedure is to sew a suture through the spot previously held by the band extender. The suture loop is left to a length of 3 cm and an air knot is tied. The suture now allows easier manipulation of the band. After unlocking the band, a new spot is then found along the lesser curvature to tunnel the band. The dissector is passed posterior to the stomach. The same suture we used to manipulate the band is now hooked to the dissector tip to position and lock the band. The band is further secured with fixation sutures placed on the gastric wall around the band.

Results: Post-operative upper GI demonstrates the band to be in good position.

Conclusion: Placing a suture through the band allows an easier way to handle the band.

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CONVERSION OF RYGB TO SLEEVE GASTRECTOMY FOR REFACTORY MARGINAL ULCER

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Background: We present a 27 yo male who underwent RYGB for morbid obesity for a BMI of 62. He had excellent results with respect to weight loss, having lost 250lbs. He unfortunately developed symptomatic marginal ulceration with repeated upper GI bleeding. He initially underwent GJ revision, but had subsequent bleeding with a hgb drop to 45. Because of persistent symptoms, and patient wishes, we proceeded with conversion to sleeve gastrectomy.

Methods: video submission uploaded to ASMBS YouTube account.

Results: see above.

Conclusion: Conversion to sleeve gastrectomy has been successful in short term follow up. He was discharged home on post-op day #2 and has not regained any weight.

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LAPAROSCOPIC GASTRIC PLICATION: A DESCRIPTION OF TECHNIQUE

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Background: Laparoscopic gastric greater curvature plication (LGGCP) -also known as Gastric Imbrication- is a relatively new bariatric procedure which has emerged as a cost-effective surgical option that does not involve gastric resection, or the use of a prosthetic device. Having shown comparable 3-year excess weight loss results as well as significantly lower incidences of major complications when compared to other restrictive procedures, LGGCP has been increasingly advocated for morbidly obese patients considering surgical intervention. In this video, we describe our LGGCP technique for bariatric surgeons looking to adopt this novel procedure in their practice.

Methods: Following the mobilization of the greater curvature, plication begins 1-2 cm from the gastroesophageal junction and up to 4-5 cm from the pylorus. It consists of a dual invagination of the greater curvature towards the lesser curvature, held in place by two lines of running, non-absorbable sutures.

Results: All patients who've undergone the procedure did well postoperatively with no complications.

Conclusion: LGGCP is a feasible surgical option for morbidly obese patients seeking surgical intervention.

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LAPAROSCOPIC REVERSAL OF ROUX-EN-Y GASTRIC BYPASS AND SLEEVE GASTRECTOMY FOR HYPERINSULINEMIC HYPOGLYCEMIA

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Background: Non-insulinoma pancreatogenous hypoglycemia syndrome (NIPHS) occurs in <1% of the Roux-en-Y Gastric Bypass (RYGB) patients. Though the treatment of refractory NIPHS is traditionally a subtotal or distal pancreatectomy, we present a case which was managed successfully by laparoscopic reversal of the previous gastric bypass, with complete resolution of symptoms.

Methods: This was a 56 year old female who had had an open RYGB 8 years ago. The operation did well from the bariatric standpoint, but patient started experiencing recurrent hypoglycemic episodes which manifested many a times in the form of syncopal attacks. She failed all the medical management, and her investigations were suggestive of post bypass non-insulinoma hyperinsulinemic hypoglycemia. A combined decision with her endocrine surgeon was taken to reverse the Gastric Bypass. The whole case was done laparoscopically. The previous surgery was a retro-colic, retro-gastric open Roux-en-Y bypass. Meticulous adhesiolysis was done to reach to the previously operated areas. A small sliding hernia was also found, which was primary suture repaired. Then the gastro-jejunosomy and the jejunojejunosomy were reversed and the gastro-gastric anastomosis done. The continuity of the small bowel was established with a side to side jejuno-jejunal anastomosis. Because the patient wanted to still have some sort of bariatric control after reversal, a Sleeve Gastrectomy was done in the end.

Results: The operating time was 420 minutes and the estimated blood loss was 150 cc. She was discharged 72hrs after surgery. She did not have a single hypoglycemic episode in the hospital. She continued to be eu-glycemic 3 months after the surgery on follow-up.

Conclusion: Laparoscopic reversal of Gastric Bypass is technically feasible, and a possible alternative to pancreatectomy for refractory post bypass NIPHS.
