ONE PORT, TWO PROCEDURES: HIATAL PLASTY AND VERTICAL SLEEVE GASTRECTOMY IN LAPAROSCOPIC SURGERY

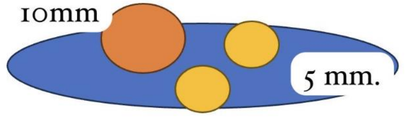
Authors:;Miguel Zapata, MD; Julio Gallardo, MD; Adrian Gonzalez, MD; Lucia Cano, MD; Bernardo Fernandez, MD; Hospital Christus Muguerza Alta Especialidad, Monterret, México

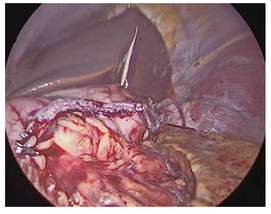
INTRODUCTION

Vertical sleeve gastrectomy is one of the most frequently performed bariatric procedures in the world. Single-incision laparoscopic surgery is performed using just a single port for the whole surgery, compared to the usual technique that uses 5 ports. We present a 22-year-old female patient, with obesity refractory to hygienic-dietary measures (BMI of 34.2 kg/m2), without symptoms of gastroesophageal reflux and reflux data in a gastroduodenal series. The patient underwent a gastric sleeve surgery through a single port, as an intraoperative finding a type I hiatal hernia was observed, so a hiatal plasty was performed, the patient maintained good postoperative evolution and was discharged on the 2nd postoperative day

CONCLUSIONS

In addition to a better aesthetic result, the reduction of trauma to the abdominal wall results in less postoperative pain, less bleeding, faster recovery and lower risk of wound complications are great advantages of this technique. Gastric sleeve and hiatal plasty via single port has been shown to be feasible and offers the opportunity to maintain a single incision approach.





CASE PRESENTATION

The procedure began with the patient in the French position, a 4 cm transumbilical incision was made, the space was digitally freed to begin the pneumoperitoneum with the Veres technique and subsequently a 10 mm trocar and two other 5 mm trocars were placed with a distance of 1.5 cm in triangular shape. Once the pressure of 15 mmHg was achieved, a 30º lens was introduced through a 5 mm port and conventional laparoscopic forceps were placed through the other two ports. A retrator was used to retract the liver and visualize the hiatus and the gastric chamber. A 40 Fr esophageal calibration probe was placed and dissection of the vasculature began 5 cm proximal to the pylorus.

The vasculature was sectioned from that point to the angle of His using advanced bipolar energy sealing and cutting technology. Subsequently, a the plasty was performed, the pillars were closed with Ethibond-0 suture cross stitches, visualizing the orogastric tube passing easily through the esophagus. Stapling of the greater curvature was performed with a 60 mm cartridges stapler. An airtightness test was performed with methylene blue using an orogastic probe, which was negative. Subsequently, staple-line hemostasis was verified and laparoscopic instruments were 6/6 removed by extracting the stomach segment through the transumbilical incision. The patient was discharged after 48 hours of hospital stay without postoperative complications. He remained under monthly follow-up with adequate progress.

