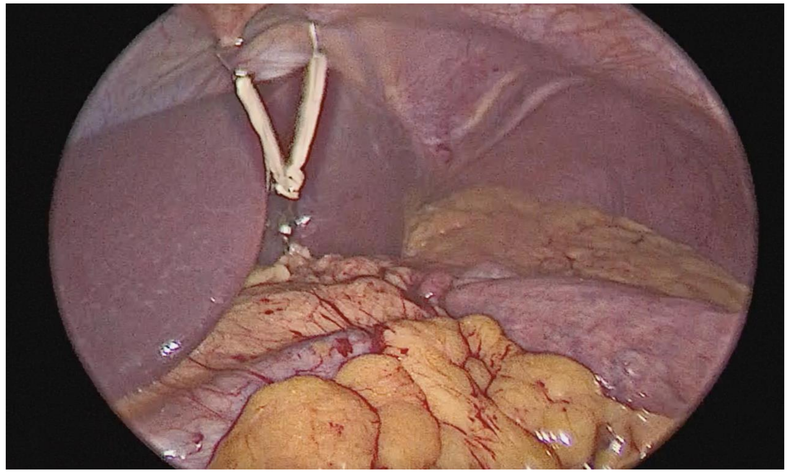
STREAMLINED SURGERY: COMBINING SINGLE-PORT GASTRIC BYPASS WITH CHOLECYSTECTOMY

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INTRODUCTION

Gallstones disease has a global prevalence around 10-20%. It has been described that obesity is an independent risk factor for development of gallstones. Metabolic bariatric surgery achieve significant and sustainable weight loss in patients suffering from severe obesity. Rapid weigh-loss is a risk factor for gallstones, as it accelerates the elimination of cholesterol and increase bile cholesterol saturation index, subsequently an increased risk of symptomatic gallstones. Single-incision transumbilical laparoscopic approach (SILS) have gained popularity. Besides this, there are few reports informing about the combination of procedures by single port.



CASE PRESENTATION

We present the case of a 45 year old woman, with a BMI of 42 kgm^2 .In the preoperative evaluation an abdominal ultrasound showed cholecystolithiasis. Therefore, we proposed to combine a Roux-en-Y Gastric Bypass and Cholecystectomy through a single transumbilical port access. The procedure started with the patient in a modified lithotomy position, under balanced general anesthesia. A 4cm transumbilical incision was made. Pneumoperitoneum was performed with a Verres needle and a 10mm trocar and two other 5mm trocars were placed at a distance of 1.5 cm in a triangular shape. A 30º lens was inserted through the 5mm port and tweezers were placed through the other ports. Cinch Organ Retractor® was used to retract the liver and expose the gastric chamber. A 36 Fr esophageal tube was placed, the gastric chamber was identified, and a retrogastric tunnel was made 6 cm distal to the gastroesophageal junction. The new reservoir was created using a laparoscopic Echelon Flex stapler (Ethicon®) with 60mm cartridges. An hermetic test was performed without evidence of leaks. Subsequently, the angle of Treitz was located and 90 cm distal from it, an intestinal trasnsection was made using previous stapler. Then the jejuno-jejunum laterolateral anasmotosis was performed 115 cm distal to the previous cut using again Echelon Flex Sapler. The anastomoses were closed with 2-0 vicryl and mesenteric defects were closed with ethibond 2-0. Gastro-jejunum anastomosis was made antecolic and manually using two planes with 2-0 vicryl. Subsequently, a cholecystectomy was performed, mobilizing the Cinch Organ Retractor® to retract the gallbladder laterally and cephalad, dissection was performed with monopolar energy and subsequently the hepatocystic triangle was exposed to place two proximal clips and one distal on the duct and cystic artery. Instruments were removed at the same time as the surgical specimen and the single incision was closed with cross stitches of absorbable suture and skin with inverted 3-0 Monocryl sutures. The procedure lasted 110 min and 50 ml of bleeding was quantified. The patient was discharged after 48 hours of hospital stay without complications. The patient was followed monthly, obtaining expected weight loss, good aesthetic results and an imperceptible scar.

CONCLUSIONS

Adaptation of a conventional laparoscopic approach to a single incisión approach requires mastery of the technique and skills of the surgeon. The main limitation is the limited number of trocars that can be placed within the single incisión and that there is no consensus of a prohylactic procedure such a cholecystectomy during a bariatric procedure. The advantages are: better aesthetic result, the reduction of trauma to the abdominal wall results in less pain, less bleeding and a quicker recovery. In this patient we have not seen tha apperance of post-incisional hernia. This report shows that a bariatric surgery alone or combined with other procedure through a single port is feasible and offers the opportunity for a single incision approach.

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