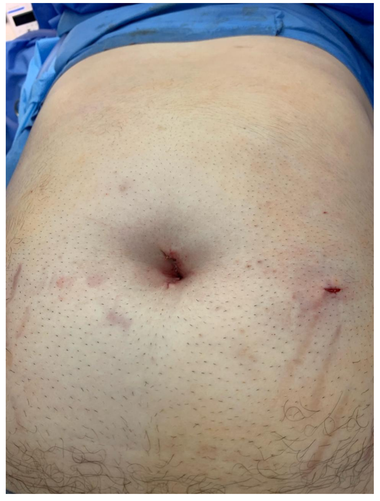
One Port, Many Possibilities: A Series on Gastric Bypass for Obesity Management

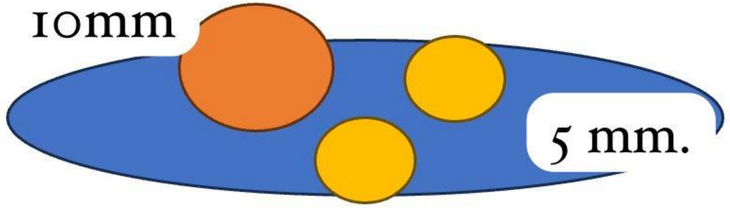
MÉDICOS RESIDENTES DE LA UNIVERSIDAD DE MONTERREY Y CHRISTUS MUGUERZA / MONTERREY, NUEVO LEÓN, MEXICO

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INTRODUCTION

Conventional laparoscopic Roux-en-Y gastric bypass has not yet been established as the gold standard in bariatric procedures. Laparoscopic Roux-en-Y gastric bypass, has numerous advantages over the open approach, however the laparoscopic approach typically requires 5 to 7 laparoscopic ports. We present the first described series of cases of laparoscopic Roux-en-Y gastric bypass with single 5 mm port access.





CASE PRESENTATION

A 4cm transumbilical incision is made. Pneumoperitoneum is performed with a Verres needle and a 10mm trocar and two other 5mm trocars are placed at a distance of 1.5 cm in a triangular shape. A 30º lens is inserted through the 5mm port and tweezers are placed through the other ports. A 5 mm accessory port is added to the left flank and instruments are introduced. A 36 Fr esophageal tube is placed, the gastric chamber is identified, and a retrogastric tunnel is made 6 cm distal to the gastroesophageal junction. The new reservoir is created using a laparoscopic stapler with 60mm cartridges. An hermetic test is performed without evidence of leaks. Subsequently, the angle of Treitz is located and 90 cm distal from it, a cut of the small intestine with endogia is performed. Then the jejuno-jejunum laterolateral anasmotosis is performed 115 cm distal to the previous cut using again endogia. The anastomoses is closed with 2-0 vicryl and the mesenteric gap is closed with ethibond 2-0. The alimentary loop is grabbed and the antecolic gastro-jejunum anastomoses is made manually in two planes with 2-0 vicryl. The single incision is closed with cross stitches of absorbable suture and skin with inverted monocryl 3-0 sutures. The procedures takes an average of 90 minutes and 30 ml of bleeding were quantified. All our patients were 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 multiport laparoscopic approach to a single port requires mastery of the surgeon's technique and skills. The main limitation is the limited number of trocars that can be placed within the single incision.The advantages, in addition to a better aesthetic result, are the reduction of trauma to the abdominal wall which results in less pain, less bleeding and a faster recovery. Single-port gastric bypass showed that it is feasible and that it offers the opportunity for wider use of a single-incision approach.

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