

Personalized Approach to Epiphrenic Diverticula utilizing EndoFLIP

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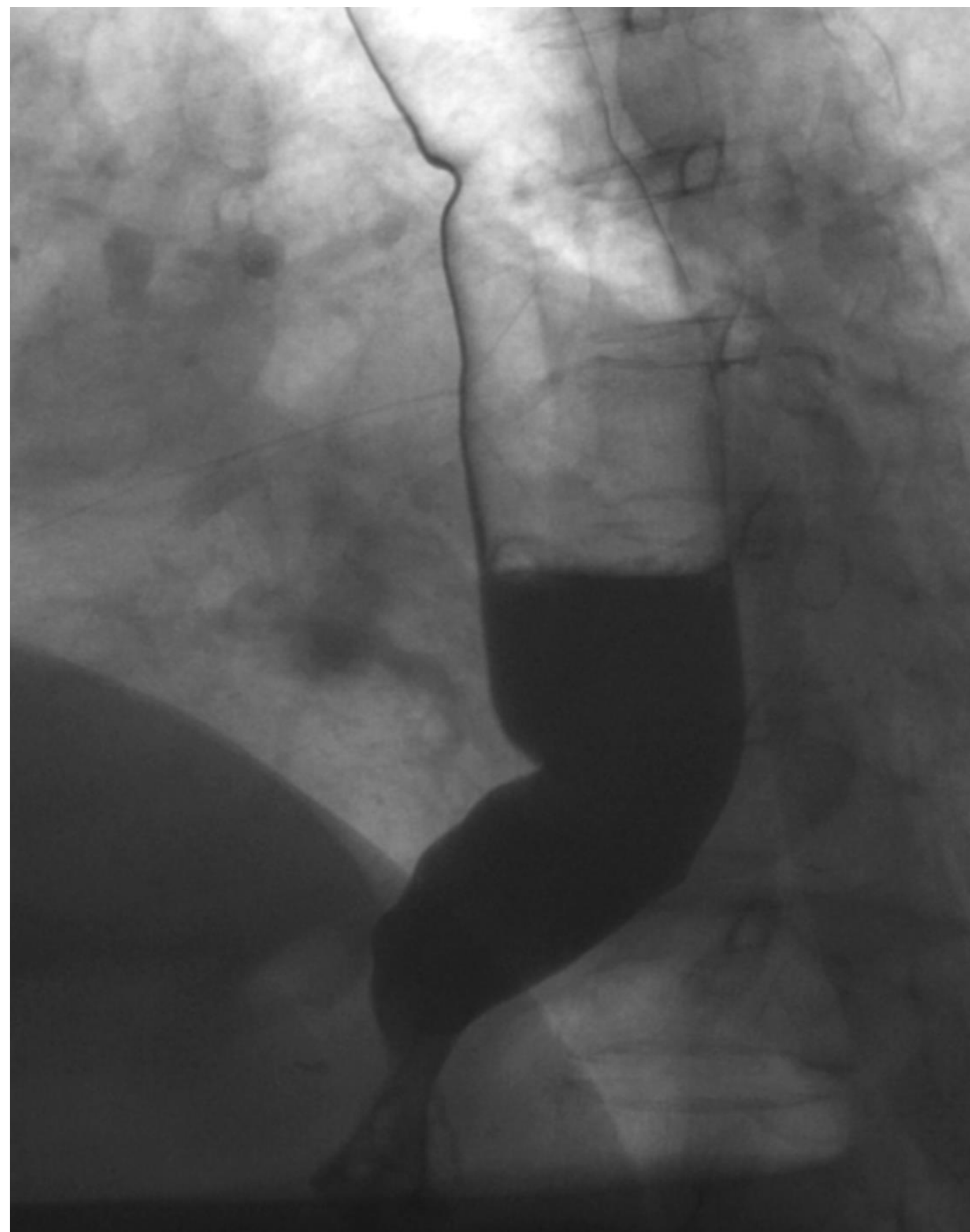
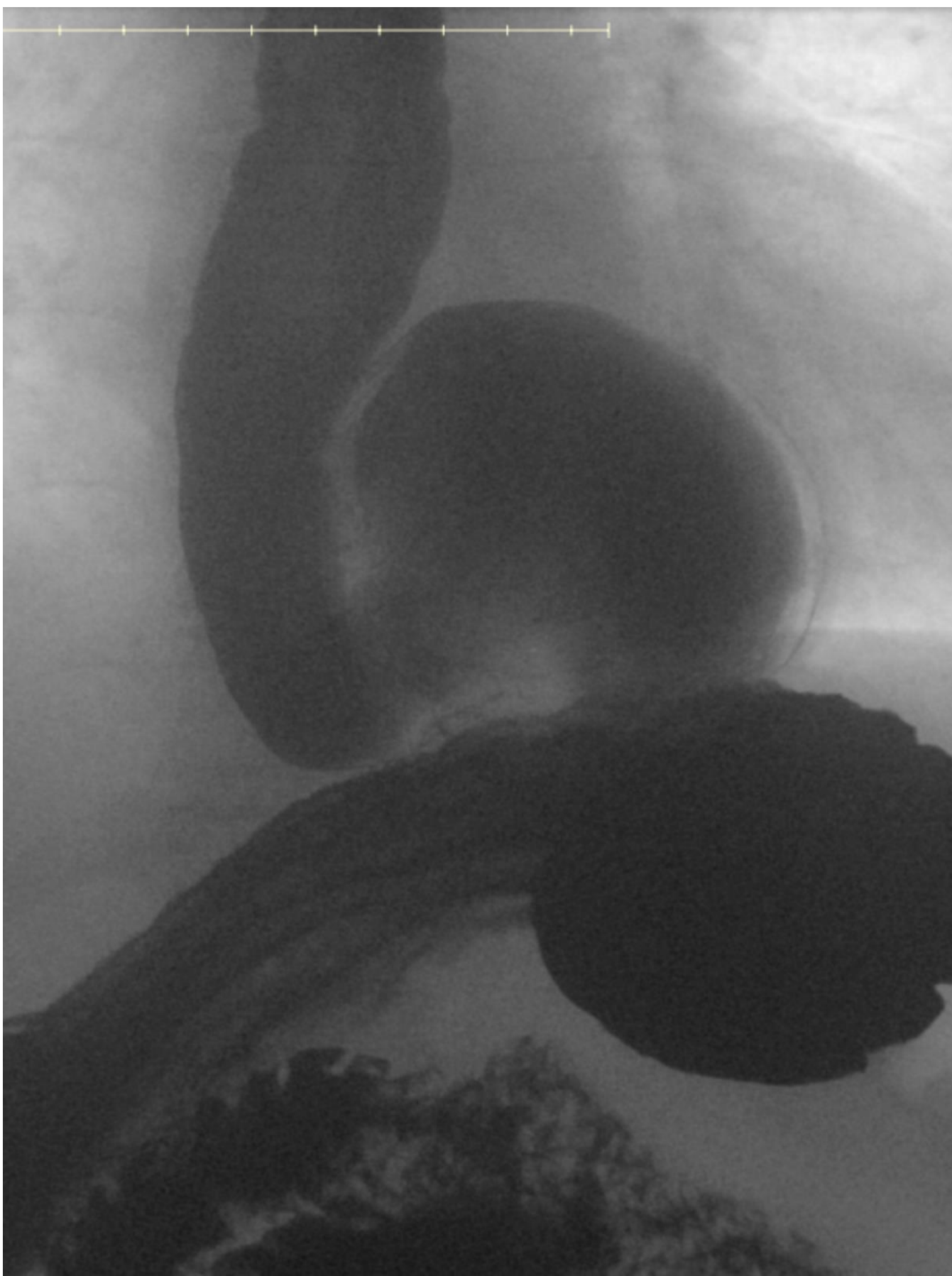
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INTRODUCTION

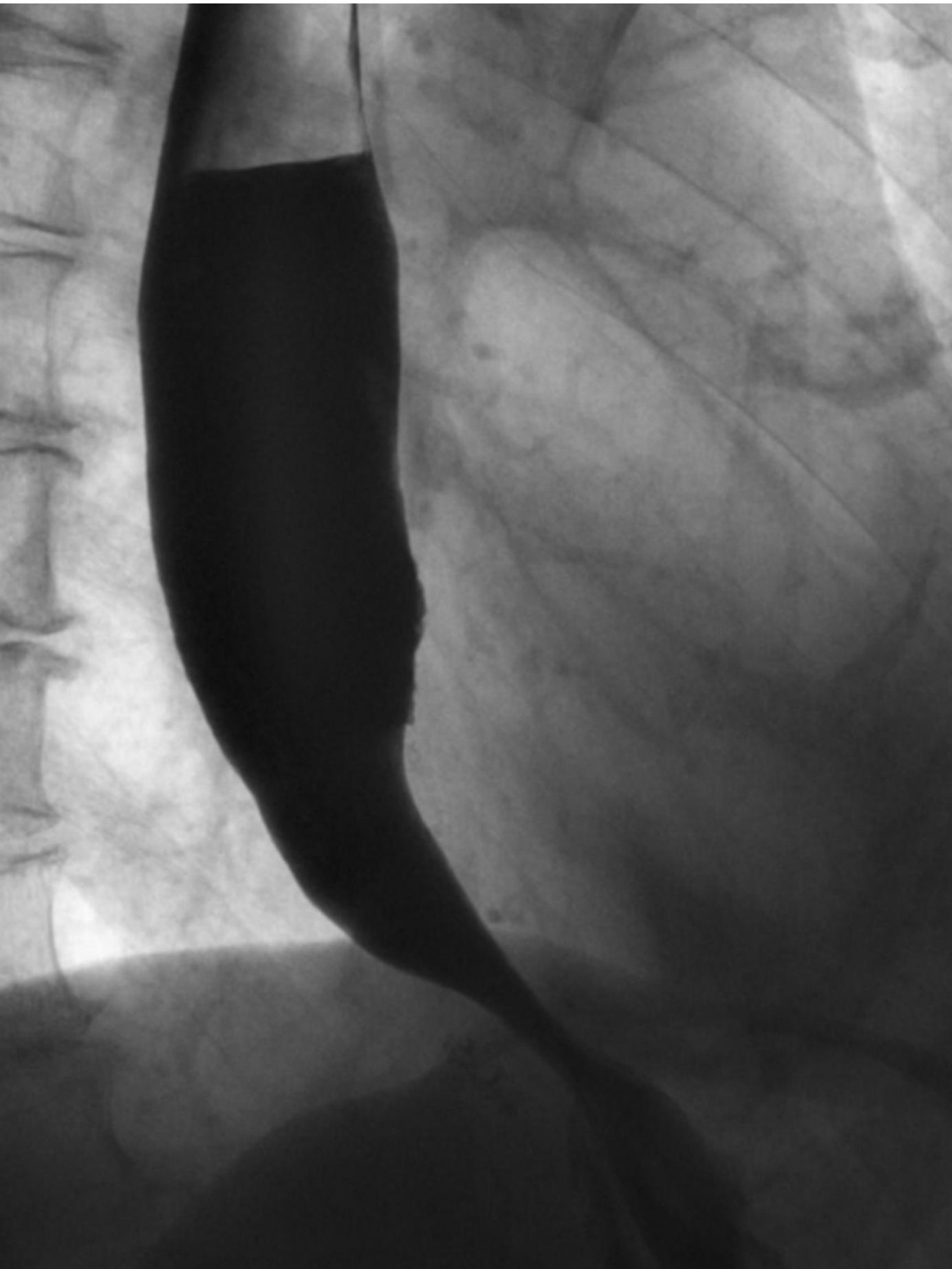
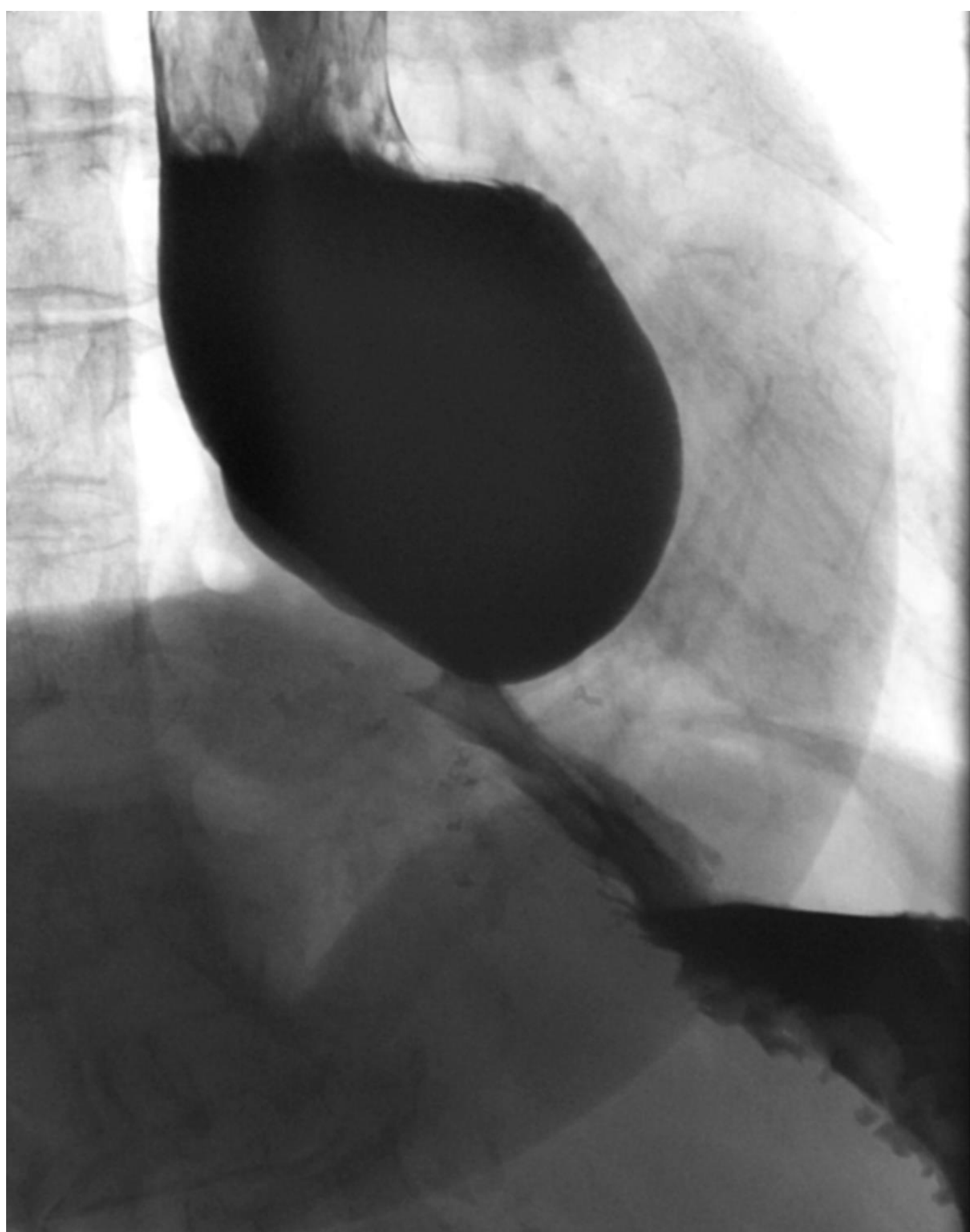
- Incidence = 3%
- Most cases are caused by increased intraluminal esophageal pressure due to dysmotility
- Surgical options: open vs MIS diverticulectomy
- Approaches: thoracic, intra-abdominal or combo *with* esophageal myotomy

CASE ONE

- 78yo F presented with progressive dysphagia, regurgitation
- Preoperative workup included manometry (40% failed swallows, 20% weak swallows, and normal resting LES pressure however the probe may not have traversed the LES) and EGD revealing a large epiphrenic diverticulum
- Balloon dilation performed without symptom improvement
- Intra-operative EndoFLIP findings revealed poor esophageal distensibility, < 2.0
- Stapled diverticulectomy performed with myotomy
- Origin: spontaneous



Case 1: Pre-operative (LEFT) and post operative (RIGHT) esophagram findings



Case 2: Pre-operative (LEFT) and post operative (RIGHT) esophagram findings

CASE TWO

- 69yo F with a history of hiatal hernia repair and Toupet fundoplication presented with dysphagia and progressive regurgitation of undigested food
- Preoperative workup included manometry (normal LES pressure with a weak DCI) and EGD which confirmed a single, large diverticulum shortly before the GE junction with a broad 3–4 cm base.
- Intraoperative EndoFLIP findings revealed significant esophageal distensibility, > 20.0
- A recurrent paraesophageal hernia was reduced with takedown of existing Toupet fundoplication followed by stapled diverticulectomy without myotomy
- Origin: presumed to be iatrogenic secondary to esophageal muscular injury and increased backpressure secondary to existing fundoplication

DISCUSSION/CONCLUSION

- EndoFLIP allowed for personalized, selective myotomy
- Minimal post-op complications
- Both patients reported symptomatic improvement upon follow up