P94
INTRAHEPATIC GLISSONIAN APPROACH FOR SINGLE-PORT LAPAROSCOPIC LEFT LATERAL SECTIONECTOMY
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Objective: Minimal access surgery is moving towards reduced size and fewer ports. In the last few years, a novel technique using single-incision laparoscopic approach has been described. Laparoscopic liver resection has been increasingly used in the past decade but there are few reports on single-port liver resection in the literature. The aim of this video is to present a single-port laparoscopic left lateral sectionectomy with intrahepatic Glissonian approach.

Methods: A 27 year-old woman with a 6-cm hepatocellular adenoma is referred for surgical treatment. Liver resection is advised and a single-port laparoscopic liver resection using intrahepatic Glissonian approach is proposed. The patient was informed about the advantages and risks of the technique, and she gave consent for its use. A transumbilical incision is performed, and a single-incision platform is introduced. The operation begins with ultrasound examination of the liver. Intrahepatic Glissonian access of the portal pedicle from segments 2 and 3 is performed, and the pedicle is divided with a stapler. The liver is transected, and the left hepatic vein is divided with a stapler. A surgical specimen is retrieved through the single umbilical incision. No drains are left in place.

Results: Operative time was 90 minutes and there was minimal bleeding. Recovery was uneventful and patient was discharged on the first postoperative day. Final pathology showed hepatocellular adenoma with no signs of malignancy.

Conclusion: Single-port laparoscopic left lateral sectionectomy is feasible and can be safely performed in specialized centers. Intrahepatic approach is a useful tool to control the Glissonian pedicle.

P95
ROBOTIC PANCREATODUODENECTOMY WITH INTRAOPERATIVE PANCREATOSCOPY FOR MAIN DUCT INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM
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Objective: Main duct variant intraductal papillary mucinous neoplasm of the pancreas (MD-IPMN) is a target for surgical therapy due to its malignant potential. Despite some guidance from the surgical literature, the extent of surgical resection for MD-IPMN is subject to controversy. Concerns over a biologic field defect and discontinuity of the neoplastic process may lead to a total pancreatectomy even in the prophylactic or precancerous setting.

Methods: This video reports the case of a 73 year old with classic radiographic and endoscopic findings of MD-IPMN who underwent robotic resection. At robotic surgery, the pancreas was transected and the patient underwent prograde and retrograde examination of the pancreatic duct with a 9.6 French digital ureteroscope.

Results: The characteristic papillary tumor was found only in the head of the pancreas and the body and tail had endoscopically normal mucosa. The patient underwent robotic pancreatoduodenectomy, avoiding total pancreatectomy. The surgery was uncomplicated and did not require an intensive care unit stay. The patient was discharged on post operative day 7.

Conclusion: Intraoperative pancreatoscopy with readily available equipment allows the resections to be tailored to the patient's burden of disease, preserving pancreatic endocrine and exocrine function. Pancreatoscopy can be performed during robotic surgery to provide a minimally invasive treatment option for patients with MD-IPMN.
P97
POSTCHOLECYSTECTOMY
SYNDROME SECONDARY TO CYSTIC
DUCT REMNANT
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Objective:
Methods:
Results:
Conclusion:

P168
LAPAROSCOPIC
PANCREATODUODENECTOMY. STEP
BY STEP
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Objective: Describe the surgical technique used in our hospital.

Methods: Surgical technique.

The patient is positioned in reverse Trendelenburg. Pneumoperitoneum 15 mmHg, 10 mm optical 30°, three 5 mm trocars and two 12 mm. Harmonic Scalpel is used as an energy device, clips to vessels and section between clips. Extended Kocher maneuver releasing the entire duodenum to the angle of Treitz, to expose vena cava. Gastrocolic ligament section. Dissection through hepatoduodenal ligament and hepatic pedicle, dissection and distal bile duct section. Transection of stomach at antrum level. Transection of jejunum, 10 cm from the Treitz. Transection of colon to the angle of Treitz, to expose vena cava. Gastrojejunostomy using stapler. The surgical specimen is removed through a suprapubic incision.

Results: This is our initial seri with good results.

Conclusion: Laparoscopic pancreaticoduodenectomy should be performed in centers with training in advanced laparoscopic surgery. The advantage of this approach includes less operative bleeding and early recovery, with morbidity and mortality equivalent to the open technique.

P169
CHOLECYSTECTOMY AND IVB-V
HEPATIC SEGMENTECTOMY WITH
COMPLETE LYMPHADENECTOMY IN
A T1B GALLBLADDER CARCINOMA.
A VIDEO CASE REPORT
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Objective: Gallbladder carcinoma (GBC) is a rare disease, often diagnosed incidentally after a routine cholecystectomy. At the earliest stage T1a, cholecystectomy alone is curative in 90–100% cases. However, T1b carcinomas have been the focus of several publications, as weather extended resection could increase survival rates, with adequate morbidity. Most experts agree that en-bloc central hepatic resection should be done, in addition to lymph node dissection and resection of the porta hepatitis and along the hepatoduodenal ligament, although there are no standards established as to the minimum number of lymph nodes examined.

Methods: We report the case of a 67 years old woman, referred from another center with the diagnosis of GBC T1b after a routine cholecystectomy. Open IVb and V hepatic segmentectomy with lymphadenectomy of periaortic, pericava and hepatoduodenal ligament’s nodes was done at our center.

Results: We expose a detailed, well-structured video in which we evidence this procedure, with clear anatomic dissection. No complications were reported after surgery, and the patient continues alive with follow up studies up to the moment. Histopathological result of the lymphadenectomy showed no neoplastic infiltration.

Conclusion: We believe radical R0 surgery is the only treatment capable of increasing GBC survival rates, especially when diagnosed at early stages.

P170
MINIMALLY INVASIVE TREATMENT
OF WALLED-OFF PANCREATIC
NECROSIS COMPROMISED BY
COLONIC FISTULA
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Objective: Walled-off pancreatic necrosis (WOPN) is a life-threatening complication of acute pancreatitis, occurring more than 4–6 weeks after the initial attack. WOPN can lead to serious additional complications such as sepsis, hemorrhage, or gastrointestinal and pancreatic fistula formation.

Our video presents a case of WOPN complicated by colonic fistula managed surgically via laparoscopic cyst-gastrostomy followed by video-assisted percutaneous pancreatic necrosectomy.

A 54 year old man was admitted to an outside hospital with alcohol-induced acute pancreatitis and subsequently developed a peri-pancreatic fluid collection. His symptoms resolved without additional intervention and he was able to resume a regular diet. Two months later the patient was admitted to our institution with sudden onset of severe abdominal pain and sepsis. Imaging studies revealed a 25 cm area of gas-containing WOPN suggestive of infected contents. A laparoscopic cyst-gastrostomy was performed evacuating a large amount of stool and solid necrotic debris confirming fistulization to the left colon. Seven days later, residual necrosis was removed via video-assisted percutaneous retroperitoneal approach utilizing a 12 mm trocar. The patient had a favorable clinical evolution and was discharged home 15 days later on enteral nutrition, having resumed normal bowel function, and with scant output from an indwelling drain. Follow-up imaging confirmed near-complete resolution of the WOPN.

Our case report illustrates the effectiveness and safety of minimally invasive approaches in the management of WOPN complicated by colonic fistula, without the need for stool diversion and open procedures.
P171
LAPAROSCOPIC HEPATECTOMY USING COMBINED SALINE LINKED RADIOFREQUENCY BIPOLAR ELECTROCAUTERY SYSTEM AND ULTRASONIC DISSECTOR FOR SUPERIOR HEMOSTASIS AND DISSECTION

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Objective: Patient with Hepatocellular carcinoma in the setting of liver cirrhosis poses surgical challenges due to coagulopathy and increased risk of hemorrhage secondary to unhealthy liver parenchyma. The video demonstrates the laparoscopic partial liver lobectomy using different energy sources, facilitating safe and effective hemostatic dissection.

Methods: This patient is a 77 year old male with a past medical history of chronic Hepatitis B, taking Hepsera, was referred 4 years prior for 1.9 cm mass in segment 4a/4b, and underwent diagnostic laparoscopy, found to have benign pathology. Recent CT Liver protocol revealed a 2.4 cm mass in segment 3, consistent with hepatocellular carcinoma. He underwent Laparoscopic partial lobectomy using the Ultrasonic Dissection and Saline Linked Radio Frequency Hemostatic devices. We start by demarcation of the mass excisional borders, followed by dissection into the liver parenchyma using the saline-linked coagulation to produce a coagulation zone of tissue, finishing with ultrasonic dissection. Veins encountered during dissection were clipped and deep tissue stapled to complete resection. The combination of these two devices facilitated a safe dissection with minimal blood loss, with the secondary benefit of simplicity.

Results: Patient tolerated the procedure well, had uneventful recovery, and discharged home on postoperative day 3.

Conclusion: Surgical resection for Hepatocellular carcinoma is the mainstay of treatment. Liver cirrhosis is present in the majority of patients with Hepatocellular carcinoma, and presents a technical challenge due to hemorrhage. Using Saline linked radiofrequency bipolar electrocautery system and ultrasonic dissector provides a safe and simple hemostatic technique in such cases.

P172
ROBOTIC LIVER RESECTION FOR RECURRENT METASTATIC GASTROINTESTINAL STROMAL TUMOR OF THE STOMACH

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Objective: Patient presented with liver metastasis 5 years post an open gastrectomy.

Methods: We describe a systematic stepwise approach to a robotic assisted resection of the liver metastasis.

Results: 50-year-old male with a history of partial gastrectomy for gastrointestinal stromal tumor 5 years ago. He developed an 8 cm solitary recurrence located at segment 6 of the liver. He underwent treatment with imatinib mesylate with good response initially and subsequently developed new enhancing nodules within the mass. A robot assisted segment 6 liver resection is described: a total of 4 robotic ports were placed and the da Vinci Xi robotic system was used with the patient placed at left lateral decubitus position. The approach entailed: 1) Diagnostic laparoscopy to confirm that there were no other visceral metastases 2) Lysis of adhesions 3) The liver surface along the segment 6 was scored using hot scissors 4) The vessel sealer was utilized for the parenchymal transection 5) Progressive intra-operative ultrasound allowed as to maintain an adequate surgical margin as well as to identify large hepatic venous branches 6) A robotic stapler was utilized to transect the hepatic venous branches 7) The right triangular ligament was released and the specimen placed in a retrieval bag. Patient had an uneventful postoperative course and was discharged home 36 hours later.

Conclusion: Robotic liver surgery is particularly useful for posteriorly placed liver tumors obviating the need for an open surgery. It can be safely done with minimally invasive techniques with minimal blood loss and short hospital stay.

P193
THE VALUE OF THE HAND DURING LAPAROSCOPIC LIVER SURGERY

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Objective: Describe the utility of the hand in laparoscopic hepatectomy for tumors located in the posterior right liver.

Methods: The patient is placed supine on the operating room table in the split-legged position over a bean-bag. The operation begins with a low transverse suprapubic incision and placement of a hand-assist port device. Three additional 12 mm working ports are placed in anticipation of the planned liver resection. A standard laparoscopic cholecystectomy is done. The left triangular and coronary ligaments are divided exposing the hepatic veins. At this point, the left hand of the primary surgeon who is positioned between the patient’s legs is introduced. The right liver is now mobilized completely exposing the right hepatic vein and lateral free edge of the inferior vena cava. With the entire liver mobilized, the tumor location is now identified both, videoscopically and by intra-operative ultrasonography. The liver is carefully marked using electrocautery making sure to allow for minimum of ~2 cm tumor margin. Ultrasound and manual palpation are critical for this purpose. The liver is divided using a combination of bipolar energy devices and EndoGIA stapler loads. The specimen is removed through the low transverse incision.

Results: Excellent tumor margin ~2 cm.

Conclusion: Early use of the hand in laparoscopic liver surgery is extremely valuable in expediting the liver mobilization and provides manual palpation during liver transection to ensure an adequate tumor margin. The low transverse suprapubic incision is well tolerated and useful for retrieving the large specimen.
P194
LAPAROSCOPIC 3D DISTAL PANCREATECTOMY AND STAPLER LINE REINFORCEMENT
H. Alghai
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**Objective:** Technical tips in laparoscopic distal pancreatectomy using 3D camera.
**Methods:** 43 years old lady presented with upper abdominal pain, ultrasound showed 12X10 cm distal pancreatic mass. EUS biopsy suggested mucinous cystadenoma of the pancreases.
**Results:** Laparoscopic distal pancreatectomy using Olympus 3D camera used to do total laparoscopic distal pancreatectomy & splenectomy.
**Conclusion:** The use of 3D camera improves the feasibility of completing laparoscopic distal pancreatectomy.

P195
EXTENDED LIVER RESECTION IN A CENTRAL BILIARY CYSTADENOMA
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**Objective:** Biliary cystadenomas are rare, less than 5% of non-parasitic liver cysts and often confused with other more common cystic disease. Its premalignant potential indicates the need for a complete surgical resection.
**Methods:** 61 year old female with a cystic tumor involving segments 3,4b,5,7 and 8; diagnosed 5 years ago and followed up by ultrasound with slow growth. CT: multilocular cyst that compress bilaterally elements of hepatic hilum. MRI: 13 cm centrally located tumor extending cephalic from the liver caudate lobe to the dome, hypointense in T1, hyperintense in T2; in contact with pancreatic head and bilateral hepatic highland displacement.
**Results:** Right extended heptectomy was performed, cholecystectomy and cholangiography were made, cystic dilatation of segment 2 biliary duct was seen, left lateral sectionectomy was performed and right lobe percutaneous biopsy were made.
**Conclusion:** Liver resection is the preferred therapeutic option for unilateral Caroli’s disease. Contralateral biopsy is mandatory to achieve diagnose of Caroli’s syndrome or disease.

P196
LAPAROSCOPIC LEFT LATERAL SECTIONECTOMY IN CAROLI’S DISEASE
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**Objective:** Caroli’s disease (CD) is a benign congenital disorder characterized by segmental cystic dilatation of the intrahepatic biliary ducts. The aim of this study was to shown laparoscopic treatment of this disease.
**Methods:** A 70 years old women consult presenting upper right quadrant abdominal pain and fever, ultrasonography shown cystic dilatation of left segmental biliary tree, MRI shows segment 2 biliary dilatation and stones.
**Results:** A laparoscopic approach was performed, cholecystectomy and cholangiography were made, cystic dilatation of segment 2 biliary duct was seen, left lateral sectionectomy was performed and right lobe percutaneous biopsy were made.
**Conclusion:** Liver resection is the preferred therapeutic option for unilateral Caroli’s disease. Contralateral biopsy is mandatory to achieve diagnose of Caroli’s syndrome or disease.

P198
TECHNICAL TIPS FOR SUBTOTAL PANCREATECTOMY FOR HUGE TUMOR (>20 CM)
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**Objective:** To discuss stepwise technical tips to do subtotal pancreatectomy for huge tumor (>20 cm) and how to avoid bleeding and achieve negative margin with no loss of pancreatic function.