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LAPAROSCOPIC MANAGEMENT OF SMALL BOWEL OBSTRUCTION SECONDARY TO INTRA-GASTRIC BALLOON MIGRATION
Ravi Aggarwal1; Kai Tai Derek Yeung1; Charalampos Haris Markakis2; Ahmed Ahmed1; 1Imperial College London, London; 2University Hospital Lewisham, London

Background: The intragastric balloon (IGB) has been used as a temporary measure for weight reduction in the morbidly obese. The Ellipse™ IGB is a capsule that is swallowed before being filled with 550mL of fluid and resides in the stomach for four months before being excreted from the gastrointestinal tract. Serious complications related to the device remain rare.

Methods: We present an unusual case of a 41-year-old woman presenting to our hospital following two days of abdominal pain and vomiting. She had an Elipse™ IGB inserted three months prior in Saudi Arabia. On examination her abdomen was distended and mildly tender on the right side. Computed tomography showed dilated small bowel with a transition zone in the mid jejunum associated with a foreign body.

Results: Laparoscopy was performed and the transition point found in the mid-jejunum. An enterotomy was made at the transition point where the balloon was visualised intra-luminally and then extracted whole. The enterotomy was closed with intracorporeal continuous absorbable sutures. The IGB was removed from the abdominal cavity in an EndoCatch device. Upper GI endoscopy was also performed to exclude any remnant of the IGB remaining in the stomach.

Conclusion: Although initial data has shown the Ellipse™ IGB to be a relatively safe and efficacious temporary measure for weight reduction, rarely complications can occur. General surgeons should be alert to this early imaging and laparoscopy are essential for management.

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DUODENAL SWITCH: SMALL BOWEL OBSTRUCTION AND INTERNAL HERNIAS
Peter Ng1; Lindsey Sharp1; Dustin Bermudez2; 1North Carolina Surgery/ Rex Bariatric Specialists, Raleigh NC

Background: Duodenal Switch post-operative complications include small bowel obstruction and internal hernias. This video presentation discusses the common causes for small bowel obstruction, demonstrating single band adhesions, mesocolic internal hernia, and mesenteric internal hernia, including clinical presentation, radiographic evaluation, reduction technique, and repair.

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LAPAROSCOPIC ANTEGRADE SLEEVE GASTRECTOMY IN THE SETTING OF A VENTRAL HERNIA WITH LOSS OF DOMAIN
Samuel Brown1; Emily Brown1; Robert Fitzgibbons2; Kalyana Nandipati1; 1Creighton University Medical Center, Papillion NE; 2Creighton University Medical Center, Louisville KY; 3Creighton University Medical Center, Omaha NE

Background: This video presentation, we present a laparoscopic antegrade sleeve gastrectomy in a 67 year-old male with morbid obesity (BMI 45) and a complex ventral hernia with substantial loss of domain. This patient presented to our clinic with a large ventral hernia that extended down to his knees. Immediate abdominal wall reconstruction was thought to be at high risk of failure given his morbid obesity. The patient had failed multiple weight loss programs, and thus we considered surgical weight loss options for him. Pre-operative imaging showed that the majority of the patient’s stomach was contained within the hernia sac, along with the rest of his intra-peritoneal organs. We offered the patient a laparoscopic sleeve gastrectomy. This case is unique because the operation was performed predominantly within the hernia sac, rather than within the true abdomen. Post-operatively, the patient developed a mild acute kidney injury that resolved with fluid administration. He had no other complications and he was discharged from the hospital on post-operative day 4. At his 6 week follow up appointment, the patient had lost 34 lbs and his BMI had decreased from 45 to 39.

Conclusion: Laparoscopic antegrade sleeve gastrectomy can be a feasible option for patients with complex ventral hernias that involve significant loss of domain and challenging anatomy.

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LAPAROSCOPIC REPAIR OF CHRONIC GASTRO-CUTANEOUS FISTULA FROM THE EXCLUDED STOMACH 19 YEARS AFTER GASTRIC BYPASS
Anirudha goparaju1; Patricia Cherasard2; Venkata Kella2; Jun Levine3; Collin Brathwaite3; 1NYU winthrop, LONG ISLAND CITY NY; 2NYU winthrop, Garden City NY; 3NYU winthrop, Patchogue NY

Background: Gastrocutaneous fistula after gastric bypass is a rare complication. Causes includeiatrogenic, traumatic or inflammatory etiologies. Pain and wound complications are debilitating. Multiple approaches exist including percutaneous, endoscopic, and surgical options. Endoscopic approaches involve clipping and fistula plugs and stenting to seal and exclude the fistula. Multiple approaches exist including percutaneous, endoscopic, and surgical options. Endoscopic approaches involve clipping and fistula plugs and stenting to seal and exclude the fistula.

Methods: We present a case of a 75-year-old woman with a history of open non-divided gastric bypass 19 years prior that presented with a chronic draining intercostal wound. This started after a thoracoscopic lung and rib resection that was complicated by an infected wound requiring debridement. Surgical history includes splenectomy, abdominoplasty, and ventral herniorrhaphy. The diagnosis was confirmed by fistulogram, which revealed filling of the excluded stomach. Endoscopic approach was not feasible due to the location. Despite multiple abdominal surgeries, a minimally invasive approach was feasible. Access was gained via optical trocar insertion into the right upper quadrant. Additional access ports were placed in the right flank. Extensive adhesive disease was encountered and dissected sharply. The fistula was identified in the left upper quadrant and with great care the tract was dissected circumferentially and sharply divided. The portion of the excluded stomach with the fistula was resected with a linear stapler. The overlying abdominal wall was debrided and packed.
Results: The patient had a normal upper GI and was discharged home with local wound care after tolerating a diet on post-operative day 4.

Conclusion: A minimally invasive surgical approach is feasible to manage chronically gastrocutaneous fistula in the setting of multiple prior surgeries.

A VIDEO OF AN IATROGENIC PORTAL VEIN INJURY DURING DUODENAL DISSECTION FOR SINGLE ANASTOMOSIS DUODENO-ILEAL BYPASS

Scott Steinberg; Amit Surf; Daniel Cottam; Benjamin Horsley; Samuel Cottam. Emory Healthcare, Decatur GA; Bariatric Medicine Institute, South Salt Lake City UT; Bariatric Medical Institute, Salt Lake City UT

Background: The single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) surgery is technically demanding because of duodenal dissection over the head of the pancreas. However, there have not been any reports of extra-hepatic portal triad injury during duodenal dissection. Herein we report the first case of a portal vein injury during duodenal dissection. Additionally, we attempt to demonstrate the root cause of this intra-operative complication, and how to avoid this type of injury in the future.

Results: The procedure was completed without complications and the patient tolerated it very well, with minimal blood loss, the patient was discharged home postoperatively on day 1.

Conclusion: Closure of the diaphragm with barbed suture and pexy of the triangular ligament showed great results.

LAPAROSCOPIC HIATAL HERNIA REPAIR AND POUCH PEXY IN A ROUX-EN-Y GASTRIC BY-PASS PATIENT

Cristina Vila Zarate; Maria Fonseca; Vicente Cogollo; Emanuele Lo Menzo; Raul Rosenthal. Cleveland Clinic Florida, Weston FL; Cleveland Clinic Florida, North Miami Beach FL

Background: Hiatal hernia is a common disease with a high prevalence among population with obesity due to the increase in the intra-abdominal pressure.

Objective: To present a laparoscopic video of a hiatal hernia fixing with pexy of the triangular ligament after a previous repair and Roux in Y Gastric Bypass.

Methods: We present a case of a 67 years old female with severe reflux symptoms of 2 months of evolution that did not resolve with medication. She had a surgical history of Roux en Y Gastric Bypass and Hiatal hernia repair in the same operative procedure 11 years ago. In the OR after accessing the abdominal cavity the liver was cranially retracted. GE junction was exposed and a type 2 hiatal hernia with herniation of the pouch into the mediastinum was visualized. We dissected between the pouch, Liver, the right and left crus of the diaphragm until we were able to take down and reduce the pouch into the abdominal cavity. We reestablished the length of the intra-abdominal esophagus, then the diaphragmatic crus was suture posteriorly and anteriorly with running and figure of eight with 2.0 Prolene Quill Suture respectively, the pouch was then fixated to the triangular ligament with interrupted 0 silk sutures.

Results: The patient tolerated it very well, with minimal blood loss, the patient was discharged home postoperatively on day 1.

Conclusion: Closure of the diaphragm with barbed suture and pexy of the triangular ligament showed great results.

LAPAROSCOPIC REVERSAL OF A GASTRIC BYPASS FOR SHORTGUT FROM A MISSED INTERNAL HERNIA

Rana Pullatt. Medical University of South Carolina, Mt Pleasant SC

Background: The patient had a Roux en Y gastric bypass two years ago and had presented to an outside hospital for increasing abdominal pain. The patient was evaluated in the ER and was evaluated with a CT scan which was read as normal with no obstruction. General Surgery was consulted and felt patient would be appropriate for a medical floor bed. Patient was admitted to the medicine service with presumed diagnosis of marginal ulcer, placed on PPI and pain medications and GI medicine consult was obtained. Gastroenterology agreed with PPI’s and scheduled pt for outpatient endoscopy after discharge. Over the weekend patient’s pain medications were escalated and on Monday morning patient begged his attending physician and stated “this amount of pain cannot be normal”. The attending physician arranged for an inpatient endoscopy. Endoscopy revealed a necrotic roux limb. The patient was then transferred emergently to a nearby hospital that had a Bariatric Surgeon who emergently explored the patient and found necrotic bowel from an internal hernia with volvulus and resected bowel and refashioned the gj and recreated a jejunojejunostomy. Patient was left with 200 cm of total small bowel length with a 50 cm roux limb. Over the next several months patient had tremendous diarrhea and was treated with antidiarrheal agents, gatex and enteral supplementation. When pt was referred to us his albumin was 1.2 with anasarca. For 3 months he was given TPN and when his albumin was 2.8 we took him for a reversal.