Endoscopy of the stomach confirmed a poorly differentiated adenocarcinoma of the gastric cardia (intestinal type, Siewert Type II AEG) with the suspicion of paragastric lymph node metastasis.
The consensus of our Comprehensive Cancer Center was a neoadjuvant FLOT-chemotherapy followed by radical resection.
The Patient presented again during chemotherapy in April 2019 complaining of discomfort and epigastric pain. Endoscopy showed a partial regress of the primary tumor and on CT scan a progress of the potential lymph node metastases. Due to the symptoms and findings early resection was recommended.
On surgery extensive tumor masses were found around the lesser curve and around the peritoneal cavity not like lymph node metastases. An radical resection with intrathoracic anastomoses with gastric pull up was performed. The patient was discharged 4 weeks postoperatively.
The histopathological findings showed 2 other synchronous cancers besides the adenocarcinoma of the gastric cardia **(ypT1b, L0;V1,G3,R0, HER2-negative, no microsatellite instability).** It showed an early stage of squamous cell carcinoma of the esophagus **(pT1a (m3-Type), Gn0 (0/21), L0, V0, G1, R0)** and the potential paragastric lymphnode metastasis revealed to be a rare high-risk wild-type GIST of the stomach which showed a high mitotic index **(> 120 mitoses/15 high-power fields).**
The patient was readmitted to our hospital because of severe epigastric pain. A CT-Scan showed a massive progress and local recurrence of the GIST with a diameter of 7cm and infiltration into the portal vein and ascites with suspicion on peritoneal carcinomatosis. Despite the attempt of a sunitinib therapy the patient died in the beginning of May 2019 in a palliative setting .

Conclusion: There have only been few reports in the literature of synchronous triple cancer of gastric GIST, esophageal squamous cell carcinoma, and gastric adenocarcinoma.
In our case we considered the gastric adenocarcinoma to be a middle stage cancer and the squamous cell carcinoma an early stage esophageal cancer. The incidental finding of the high-grade gastric GIST with a high mitotic index and unfavorable histopathological features as the wild-type confirmation was probably the cause of death of the patient.

P179 THORACOSCOPIC EXTENDED 2-FIELD LYMPH NODE DISSECTION FOR ESOPHAGEAL CANCER. IMPLEMENTATION AND SURGICAL TECHNIQUE

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Aim: Lymphadenectomy in minimally-invasive esophageal cancer surgery still remains challenging and standardization of surgical procedures is of extreme importance. The aim of this study is to present our safe and reproducible technique in thoracoscopic superior lymphadenectomy during esophagectomy for cancer.

Background and Methods: In esophageal cancer surgery, dissection of the superior mediastinal lymph-nodes is of high importance. For adequate mediastinal lymph-node dissection, an extensive operating field is required along with appropriate equipment and experience. Thoracoscopy in prone position provides excellent visualization of the operative field comparing to thoracotomic phase. A step-by-step explanation of our surgical technique during thoracoscopic superior lymphadenectomy is provided.

Results: All patients were placed in prone position. The entire posterior mediastinal pleura was incised; azygos arch was divided with clips, facilitating dissection of the left side of the posterior mediastinum. The descending thoracic aorta was freed anteriorly, separating the esophagus; the thoracic duct was dissected and divided with vascular clips. Esophageal hiatus was dissected circumferentially and the esophageal wall was freed from the pericardiumanteriorly. Subcarinal lymph-nodes were dissected en bloc. Upper thoracic esophagus was separated from the membranous part of the trachea. The right recurrent laryngeal nerve lymph nodes were dissected at the level of the right subclavian artery, with extreme caution to avoid nerveinjury. Left recurrent laryngeal nerve was identified by posterior traction of the esophagus using a full thickness transluminal suture;by pulling it through a separate skin incision, the relative lymph nodes were dissected.

Conclusion: It is interesting that, higher number of lymph-nodes are harvested with this procedure which may be the result of better visualization/access. Overall, our technique has been standardized, is safe and reproducible and could be adopted by specialized Upper GI Units.

P180 OPTIMIZING UPPER MEDIASTINAL LYMPHADENECTOMY DURING MINIMALLY INVASIVE OESOPHAGECTOMY IN PRONE POSITION: FROM 2D THORACOSCOPY AND DOUBLE LUMEN (DL) ENDOTRACHEAL TUBE VENTILATION TO 3D THORACOSCOPY AND SINGLE LUMEN (SL) TUBE VENTILATION

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Aim: Upper mediastinal lymphadenectomy is a fundamental step of a radical oesophagectomy. Nodal dissection around the recurrent laryngeal nerves may be difficult and different approaches have been described in minimally invasive surgery. We describe our experience including recent technological advancements leading to improved outcomes.

Background and Methods: A retrospective analysis was performed among patients who underwent minimally invasive oesophageal resection for cancer including upper mediastinal lymphadenectomy between January 2016 and October 2018 at our Regional Centre for Oesophago-gastric Surgery (Broomfield Hospital, Chelmsford). A comparison between the initial cases performed using 2D thoracoscopy and DL endotracheal tube ventilation vs the more recent ones adopting 3D technology and SL tube ventilation was carried out.
Length of operative time for this part of the operation, number of nodes removed and related peri-operative complications were among the data collected.

Results: A total of 14 patients were included in the study. 2D thoracoscopy and DL endotracheal tube ventilation was used in 10 patients whilst 3D technology and SL tube ventilation was adopted in 4 cases. Operative time was reduced in the 3D group. Complications related to upper mediastinal lymphadenectomy were noted in 5 patients (all of the 2D group) and included 5 recurrent laryngeal nerve palsies and 2 temporary tracheostomies for glottis oedema. There was no significant difference in the number of nodes retrieved.

Conclusion: Lymphadenectomy of the upper mediastinal nodes can be challenging and is associated with significant morbidity. In our experience, the use of SL tube ventilation facilitates the retraction of the trachea and the exposure of the area, and 3D thoracoscopy gives optimal magnified visualization of the recurrent nerves reducing the risk of damage.

P182 3D TECHNOLOGY IN MINIMALLY INVASIVE UPPER GI SURGERY: COMPARISON BETWEEN DIFFERENT SYSTEMS

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Aim: Three-dimensional laparoscopy improves the depth of perception during minimally invasive surgery, leading to better visibility and more precise dissection, and providing better clinical and surgical outcomes in complex surgical procedures. The aim of this study was to compare the pros and cons of the 3D technological systems available in our Unit for UGI surgery.

Background and Methods: In our Unit, we have two different 3D systems for abdominal and thoracic surgery. B Braun has the EinsteinVision 3D system with 0 and 30 degree fixed camera. Olympus produces an Endoeye Flex with an articulating tip 0 degree 3D camera as well as an Endoeye 3D 0 and 30 degree rotating camera. Advantages and disadvantages of the different 3D systems were evaluated on the basis of the experience of our senior surgeons performing routinely 3D operations.

Results: All surgeons agreed of the superiority of 3D vision compared to conventional 2D laparoscopy or thoracoscopy. The B Braun system is not available in an integrated operating theatre system and does not allow image rotation, but provides a full HD sharp resolution and has the advantage of a reusable camera with single use warming cover which could be used for unlimited procedures every day. The Olympus Endoeye Flex does not provide HD resolution and can be more difficult to manoeuvre, but has the advantage of the articulating tip. The Olympus Endoeye 30 degree rotating camera has a