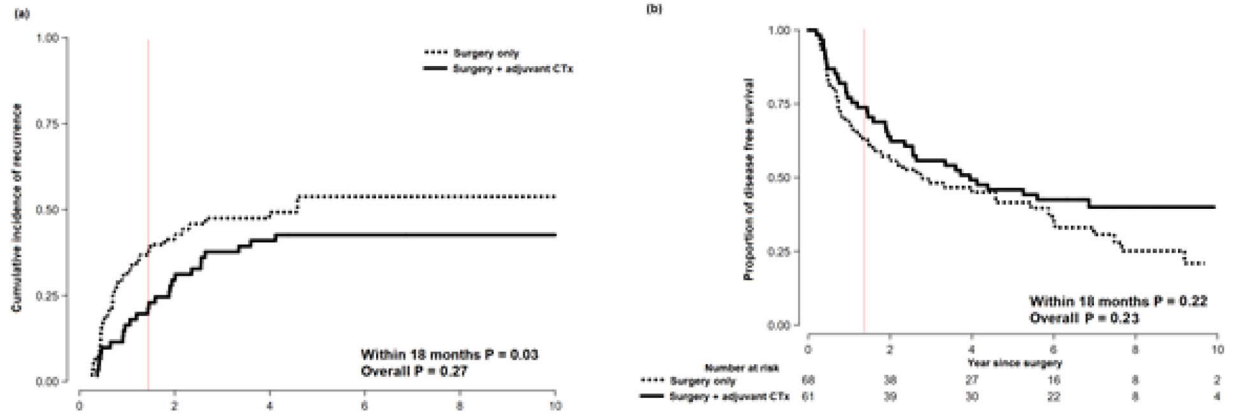

356 DIVERTICULECTOMY WITH EXTEND MYOTOMY AND ANTERIOR FUNDOPLICATION AS TREATMENT OF INTRATHORACIC ESOPHAGEAL DIVERTICULUM. CASE REPORT AND REVIEW!

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Diverticula of the thoracic esophagus are uncommon disorders and its most appropriate treatment continues unclear. The majority of these diverticula are results of underlying esophageal motility disorders, but some cases are results of periesophageal inflammation. The patients can be asymptomatic, or present dysphagia, regurgitation, aspirated pneumonia, retrosternal pain and weight loss. The barium esophagogram is considered the best study to show and evaluate these cases. Esophageal manometry allow study the esophageal motility abnormality.

Methods Patients with small and asymptomatic diverticula could not require any treatment. Patients with symptomatic or big diverticula should be submitted a diverticulectomy and often with an esophageal myotomy. However the necessity, the esophageal extension and local of the myotomy are still unclear. We describe a case of a 70 yo woman with a intrathoracic esophageal diverticulum. She presented progressive dysphagia to solids in the last two years, associated to regurgitation, retrosternal pain, nausea and weight loss of 10 kilograms. She has no history of aspirated pneumonia.

Results The upper GI endoscopy showed the diverticulum in middle esophagus (25 cm from superior dental arch) and the size in barium esophagogram was 6,5 x 4,8 cm. The high resolution esophageal manometry was normal and the patient had no tuberculosis history. She was submitted a thoracoscopic diverticulectomy with extend myotomy (intrathoracic and abdominal) and Dor's fundoplication. She was able to resume a liquid diet by day 3, after a normal barium esophagogram, and was discharged at the 4 post-operative day. After 9 months the patient remains asymptomatic.

Conclusion In our experience, the diverticulectomy associated with an extend myotomy bring excellent results at the esophageal function, allowing an adequate emptying of the esophagus, avoiding severe complications as mediastinitis or esophageal leakage even in patients without severe motility disorder.

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357 HAND-SEWN VERSUS STAPLED CERVICAL ESOPHAGOGASTRIC ANASTOMOSIS FOR ESOPHAGEAL CARCINOMA: STUDY OF CLINICAL OUTCOMES FROM A HIGH VOLUME CENTER OF INDIA

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Esophageal cancer is a dreaded disease because of its adverse effects on swallowing and therefore the quality of life. Surgical resection offers the best outcome. The mainstay of any esophageal surgery is a well healed anastomosis without any leakage or stricture. Various techniques of anastomosis have been described. Hand sewn suture have been used since long. Surgical staplers have been recently introduced. We hereby describe a comparative study between these two surgical techniques.

Methods. Patients undergoing total esophagectomy with neck anastomosis between January 2013 and March 2019 were analysed. Esophagectomy was done by either trans-thoracic or trans-hiatal approach. The stomach was utilized as conduit and anastomosis was done in the neck in all patients. The gastric conduit was pulled into the neck by the posterior mediastinal route. End to side hand sewn anastomosis (HA) was done in 85 patients using 3-0 non absorbable sutures as a single full thickness layer. Side to side stapler anastomosis (SA) was done by posterior vertical and anterior horizontal firing of 45 mm blue linear stapler in 61 patients.

Results. The primary outcome measure was anastomotic leak. The secondary outcome measures included operative time, anastomosis time, blood loss, anastomotic stricture, mean intensive care unit(ICU) stay, ambulation, removal of intercostal drains, starting of feeding jejunostomy and oral feeds, mean hospital stay. Statistical analysis was done using SPSS. There was 9 cases anastomotic leak in the HA group while in the SA group there were none. Anastomotis stricture occurred in 12 patients in HA group while 3 werein the SA group and it's statistically significant. The anastomotic time, ICU stay, time of starting oral feeds and mean hospital stay were statistically significant.

Conclusion. A well-healed anastomosis is the mainstay of the successful outcome of esophagectomy. Anastomotic leaks and strictures were the main complications of esophageal surgery. Various techniques of anastomosis have been described over the years. HA has been the standard of care since the inception of esophageal surgery. As technology developed SA got introduced and was found to have certain advantages over HA as shown in our study. SA may be used as preferred technique for esophago-gastrostomy.

363 MANAGEMENT OF COMPLEX ADVERSE EVENTS AFTER PARAESOPHAGEAL HERNIA REPAIR: EXPERIENCE OF A HIGH-VOLUME REFERRAL CENTRE

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Adverse events after paraesophageal hernia repair (PEHR), including persistent dysphagia, acute and delayed recurrence, and gastroesophageal perforation, can present complex management challenges. Medical, endoscopic and surgical treatments may be used, but descriptions of when to employ these options and how to choose a surgical approach (e.g. open vs laparoscopic, transabdominal vs transthoracic), are limited. We sought to review the treatment and outcome for complex adverse events after PEHR.

Methods: All patients undergoing primary (elective or emergency) and revisional repair of PEH at a high volume specialized referral center were identified. Demographic data, operative details and outcomes were verified by chart review. Extracted data included patient characteristics, incidence of adverse events, and diagnostic and management strategies. Details of endoscopic and surgical interventions for complex recurrences were tabulated.