

# 755 LAPAROSCOPIC REPAIR OF GIANT PARAESOPHAGEAL HERNIAS: A SINGLE CENTER EXPERIENCE AND LITERATURE REVIEW

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Paraesophageal hernias comprise about 5–10% of all hiatal hernias. Majority of patients are asymptomatic while some may present with reflux symptoms, obstruction or bleeding. There are numerous controversies on the indications of surgery, operative approach, hernial sac excision, fundoplication and on the use of a mesh.

**Methods:** We present a series of 3 patients with giant paraesophageal hernia diagnosed in year 2020 in our institution, followed by a literature review. This study aims to assess the indications and effectiveness of laparoscopic paraesophageal hernia repair with routine sac excision, primary crural repair and fundoplication in the treatment of giant paraesophageal hernia.

**Results:** There were 3 patients in this study. Their mean age was 49. All patients had type IV hiatal hernia and the mean hernia defect was 8 cm in diameter. Laparoscopic paraesophageal hernia repair, sac excision and anterior 180 degree fundoplication was successfully done for all patients without conversion to open surgery. There was no intraoperative or post-operative complications. Mean length of stay post-op was 2 days. At one year follow-up, all patients achieved complete resolution of symptoms without new onset reflux or dysphagia.

**Conclusion:** Laparoscopic paraesophageal hernia repair with routine sac excision, primary crural repair and fundoplication is safe and effective in treating giant paraesophageal hernias. Tension free repair is the key to success. A 180-degree anterior partial wrap may be able to reduce the incidence of dysphagia.

# 756 LONG-TERM OUTCOME AFTER ENDOSCOPIC SUBMUCOSAL DISSECTION FOR ENTIRE CIRCUMFERENTIAL CT1aN0M0 ESOPHAGEAL SQUAMOUS CELL CARCINOMA

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Endoscopic submucosal dissection (ESD) is the standard treatment for cT1a esophageal squamous cell carcinoma (ESCC), however its indication for the entire circumferential lesions is still controversial because of the risk of severe stricture after ESD. Therefore, several treatment options are performed based on physicians' choice, however, each clinical course is unclear. This study aimed to clarify the long-term outcome after ESD for patients with entire circumferential cT1aN0M0 ESCC, comparing with esophagectomy or chemoradiotherapy.

**Methods:** Patients with entire circumferential cT1aN0M0 ESCC treated with ESD, chemoradiotherapy, or esophagectomy as the initial treatment between January 2010 and December 2016 in our institution were included. Patients who had a history of any malignancy at cStage II-IV within 5 years were excluded. The 5-year overall survival (OS), 5-year disease-free survival (DFS), stricture rate, refractory stricture rate (defined as requiring >6 dilations), curative resection (defined as pT1a without lymphovascular invasion and negative for vertical margin in the pathological evaluation) rate of ESD, and complete response rate of chemoradiotherapy were evaluated for each treatment.

**Results:** Of the 48 eligible patients, 25/13/10 patients were performed ESD/chemoradiotherapy/esophagectomy as an initial treatment. Curative resections rate of ESD was 72%, and additional esophagectomy and chemoradiotherapy were performed in three and one patients with non-curative resection. Complete response rate of chemoradiotherapy was 100%, however, 4 patients had recurrence thereafter. No recurrences occurred after esophagectomy in all patients treated with esophagectomy. During median follow-up of 83 months, stricture and refractory stricture rate was 80/44%

after ESD, 0/0% after chemoradiotherapy, and 20/10% after esophagectomy. The 5-year OS/DFS was 91/87% after ESD, 92/59% after chemoradiotherapy, and 90/90% after esophagectomy.

**Conclusion:** While some patients required additional treatments due to non-curative resection, the long-term survival after ESD for circumferential cT1aN0M0 ESCC was similar as those after chemoradiotherapy or esophagectomy. In contrast, the stricture and refractory stricture rate after ESD was higher than others. Further investigation in a large cohort is necessary to clarify the indication criteria of ESD for patients with the lesion.

# 757 AN APPROACH TO ACCELERATE HEALING AND SHORTEN THE HOSPITAL STAY OF PATIENTS WITH ANASTOMOTIC LEAKAGE AFTER ESOPHAGECTOMY

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To explore the comprehensive role of systemic endoscopic intervention in healing esophageal anastomotic leak. To our knowledge, this paper is the first to discuss the outcome of anastomotic leaks and the association with healing time rather than whether the leak was fully healed.

**Methods:** In total, 3919 consecutive patients with esophageal cancer who underwent esophagectomy and immediate esophageal reconstruction between January 2012 and August 2019 at Sun Yat-sen University Cancer Center were screened. In total, 203 patients (5.10%) diagnosed with postoperative anastomotic leakage were included. The participants were divided into three groups according to differences in diagnosis and treatment procedures. Ninety-four patients received conventional management, 87 patients received endoscopic diagnosis only, and the remaining 22 patients received systematic endoscopic intervention, including transnasal inner drainage, endoscopic fibrin glue repair and endoscopic clipping. The primary endpoint was overall healing of the leak after oncologic esophageal surgery.

**Results:** In total, 173 (85.2%; 95% CI, 80.3–90.1%) of the 203 patients were successfully healed, with a mean healing time of 64.42 ± 3.82 days (median: 51 days; range: 13–368 days), and the overall healing rates differed significantly among the three groups according to the stratified log-rank test ( $P < 0.001$ ). The median healing time of leakage was 44 days (95% CI: 27.15–60.86 days) in the endoscopic intervention group, 51 days (95% CI: 44.86–57.14 days) in the endoscopic diagnostic group, and 66 days (95% CI: 58.09–73.91 days) in the conventional group.

**Conclusion:** Tailored endoscopic treatment for postoperative esophageal anastomotic leakage based on endoscopic diagnosis is feasible and effective. Systematic endoscopic intervention shortened the treatment period and reduced mortality and should therefore be considered in the management of this disease.

# 761 PATIENT PREFERENCES FOR ACTIVE SURVEILLANCE VERSUS STANDARD SURGERY AFTER NEOADJUVANT CHEMORADIO THERAPY IN ESOPHAGEAL CANCER TREATMENT

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The need for standard surgical resection in esophageal cancer patients after neoadjuvant chemoradiotherapy (nCRT) is subject of debate. Possibly, active surveillance (AS) is an option for patients with a clinically complete response (cCR), in whom no vital tumor cells are detected after nCRT. In a large Dutch multicenter randomized trial (SANO trial), standard surgery is compared to AS in patients with a cCR. Within this trial, we performed a side-study on patient treatment preferences.

**Methods:** Esophageal cancer patients, who declined participation in the SANO-trial due to a strong treatment preference for either AS or surgery