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Tips, tricks and modifications for robotic 3 stage oesophagectomy and gastrectomy for Da Vinci X system

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Robotic oncosurgery is the most promising and upcoming modality for complex procedures such as esophagectomy and gastrectomy. It has expanded new horizons in terms of the anatomical aspects of organs, opening up new planes of dissections as well as the extent of lymph nodal retrieval. Intuitive has established procedure cards for many procedures but for the Thoracic esophageal part, there are none. Our institute was the first one in India to establish Robotic system X in India. Being new to this hybrid system, which doesn't have an overhead boom for instrument manipulation as well as orientation, and change of port size to 8mm, it was an initial phase of the challenge, which culminated in our own port placement modifications as well as some procedural changes for the new Robotic System X.

Methodology: We would like to put forward our tips, tricks, and modifications to the procedures done by the Robotic system X for Esophageal and gastric surgeries through short videos.

Esophageal Surgeries: Hallmark of our study is the unique port placement for the robotic arms giving access from the thoracic inlet to the diaphragmatic hiatus also, the tips like Hanging the esophagus from the roof and the technique of supra azygous dissection and lymphadenectomy along the recurrent laryngeal group of nerves is very helpful in complete 3 stage oesophagectomy.

Gastrectomy surgeries: The hallmark of our modification is the introduction of the subcostal port, which is placed 4 centimeters above the midpoint of the line joining the camera port and the Arm 3. The essence of any Gastrectomy or the Gastric part of esophagectomy for lower esophageal cancer is the D2 lymphadenectomy. The gastric part of esophagectomy is the replication of D2 lymphadenectomy done for the stomach. Approach the D2, by first starting the dissection in the lesser sac, here a search for accessory left hepatic has to be done which may be present in 10-12% of the cases then dissecting along the common hepatic artery, splenic artery that is along the superior border of pancreas along the axis of T12, L1 reaching up to the spleen then tackling the short gastric is the most useful tip. We approach the stomach from behind rather than above which prevents falling of stomach and omentum in the area of our dissection. No need of putting additional Liver retractor (only Prograsp is sufficient). This indeed would be beneficial practically for the robotic surgeons in their initial phase of learning and also the tips given during the video helpful for the experienced ones in certain crucial steps in performing a complex procedure like gastrectomy robotically with more ease.

Biography

Abhinav Y Deshpande, currently working as a fellow in robotic oncosurgery with a special interest in gastrointestinal cancers has completed his MBBS from Nagpur, India in 2009 after which he did his masters in general Surgery from prestigious King Edward Memorial Hospital, Mumbai, India. He did his MCh in surgical oncology from Gujarat Cancer and Research Institute, a tertiary care referral center from Ahmedabad, India Having a keen interest in Robotic Surgery, he was fortunate to get the prestigious Fellowship of Vattikuti Foundation (United States) at Manipal Institute, Bangalore, India under the mentorship of Dr Somashekhar who is an authority in Robotic surgery. He has also presented his paper in European Breast Cancer Organization at Amsterdam in 2016 and at Lisbon Portugal in 2017 at Advanced breast cancer with Travel fellowship. He has been affiliated to the SSO (Society of surgical oncology, US) and ESSO. He is currently working on projects like Port placement techniques in robotic surgery and the role of ICG in robotic surgery. He has got the best paper award in Robotic surgeons council of India for his presentation on Port placement modifications for da Vinci X system for various Gastrointestinal and pelvic surgeries.

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