

Introduction: Loop ileostomy reduces the morbidity associated with pelvic anastomotic leakage. However, loop ileostomy reversal carries a 10% to 30% complication rate. We present our technique for laparoscopic ileostomy closure.

Methods: We conducted a retrospective chart review of subjects undergoing laparoscopic loop ileostomy closure between 2006 and 2009. Operating time, length of hospital stay, return of bowel function, and complication rates were assessed.

Results: There were 24 (13 males) patients. Average age was 63 with a BMI of 25.9. Eighteen (75%) had a planned loop ileostomy, and 6 (25%) were emergent. Average time to reversal was 135 days. Average length of surgery was 79 minutes (range, 48 to 186), average stay was 4 days, and return to bowel function was 3.6 days. We had no wound infections. Our complication rate was 29% (n=7) and reoperation rate was 12.5% (n=3). There was one major complication, an anastomotic dehiscence.

Conclusion: A thorough well-visualized lysis of adhesions and mobilization of the stoma and surrounding small bowel is the main advantage of our approach. We had no wound infections and no reoperation for bowel obstruction, which we feel is a direct advantage of our technique. Our complication rate, and surgical time are comparable to those of the open technique.

11.158 General Surgery

Laparoscopic Colon Surgery in Obese Patients: The Way Forward

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Introduction: By the year 2025, 40% of the population in the United States will be obese. This health problem is well known to predispose to numerous diseases and to increase postoperative morbidity and mortality, particularly in open surgery. The laparoscopic approach offers the best benefit for obese patients, lowering the incidence of surgical complications. The aim of this study was to show the feasibility and the outcomes of laparoscopic colorectal surgery in obese patients.

Materials and Methods: We retrospectively reviewed 845 cases of preobese and obese (BMI \geq 25) patients who underwent colorectal surgery from January 1991 to December 2009. We compared and analyzed the different parameters, such as BMI, age, sex, associated disease, as well as the diagnosis, type (total laparoscopic vs. laparoscopic-assisted) and duration of the procedures, conversion rate, and the perioperative and postoperative complications.

Results: 363 (42.9%) patients underwent intracorporeal anastomoses, 215 (25.4) patients had laparoscopic-assisted anastomoses, and 183 (21.6%) patients had no anastomosis performed. Procedures performed totally laparoscopically had lower intraoperative (1.4% vs. 3.5%) as well as postoperative (4.8% vs. 14.7%) complication rates compared to laparoscopically assisted colectomies.

Conclusion: The laparoscopic approach has been shown to lower the incidence of pulmonary complications, incisional hernia, and wound infection, with less postoperative pain and shortened length of stay. Our findings demonstrate that the severity of obesity is a very important risk factor for complications and outcomes.

11.159 Gynecology

Laparoscopic Supracervical Hysterectomy and Vagino-Cervico-Sacropexy

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The objective of the video is to demonstrate a safe, economical technique for performing laparoscopic supracervical hysterectomy with vagino-cervico-sacropexy.

The subject of this video is a 50-year-old, G 6, P 6006, female with Grade 3 uterine prolapse, anterior compartment prolapse, pelvic pain, and a normally functioning bladder. An 8-cm firm uterus was noted. Bard polypropylene mesh was fashioned into

a “Y” graft and affixed to the anterior and posterior aspects of the cephalad-vaginal barrel and cervical stump using the Endo Stitch from Covidien and 2-0 Surgidac suture with extracorporeal knot tying. The base of the Y graft was tacked to the sacrum. The graft was then retroperitonealized.

Operating time for the entire case was 152 minutes with 110 minutes specifically dedicated to the vagino-cervico-sacropexy and closure. Use of the Endo Stitch and this technique results in a surgical time well less than that reported in a recent study¹ both for laparoscopic (269 minutes) and robotic (328 minutes) routes.

This laparoscopic technique, relying on the Endo Stitch and removing the corpus without a morcellator, saves money by markedly reducing operating room time, equipment, and associated time-related charges. Use of laparoscopy without robotic assistance further decreases cost by not adding robot-related charges and by not adding the additional time-related charges associated with robotic surgery.

1Judd JP, Siddiqui NP, Barnett JC, Visco AG, Havrilesky LJ, Wu JM. Cost-minimization analysis of robotic-assisted laparoscopic, and abdominal sacrocolpopexy. *J Minim Invasive Gynecol*. 2010;17(4):493-499.

11.160 Gynecology

Total Laparoscopic Hysterectomy and Vaginal Morcellation

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The objective of the video is to demonstrate a safe, economical technique to perform total laparoscopic hysterectomy in women with large uteri without the use of laparoscopic morcellating devices. Commercially available, laparoscopic morcellating devices from manufacturers, such as Gynecare, Gyrus, and Storz, run between \$150 and \$848 per disposable and between \$15,000 and \$30,000.00 for generator acquisition. Significant per use cost is added to the surgery when these devices are employed compared to use of standard instruments universally available in a vaginal hysterectomy tray.

The subject of this video is a 42-year-old, G 4, P 2022, female with menorrhagia, severe dysmenorrhea, and a distended, firm lower abdomen. Imaging demonstrated a uterine fibroid extending well cephalad to the umbilicus. Hemoglobin was 7.4 grams with an MCV of 62. Endometrium was benign. Total laparoscopic hysterectomy was performed with manual vaginal morcellation. Specimen weight of 1852 grams was reported with adenomyosis and leiomyomata.

Vaginal morcellation in experienced hands is quicker than its laparoscopic alternatives as the vaginal aperture is bigger and larger volumes of tissues can be removed in the same period of time. Vaginal morcellation decreases cost both by eliminating equipment costs and by decreasing operating room, time-related charges.

Because of the ongoing effort to decrease cost of healthcare while maintaining outcomes, this video demonstrates a safe, economical technique to perform total laparoscopic hysterectomy in women with large uteri without use of laparoscopic morcellating devices.

11.161 Urology

Secondary or Tertiary Treatment of Benign Prostatic Hyperplasia with GreenLight HPS™ Laser Photoselective Vaporization Prostatectomy: Clinical Outcomes

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Background and Objective: We evaluated the GreenLight HPS™ laser photoselective vaporization prostatectomy (PVP) as a treatment for symptomatic benign prostatic hyperplasia (BPH) previously treated with surgical management.

Methods: We prospectively evaluated our initial GreenLight HPS™ laser PVP experience. Only patients who failed prior