Tricks Around The Hiatus

Revisional Surgery Pre Congress Course IFSO 2024

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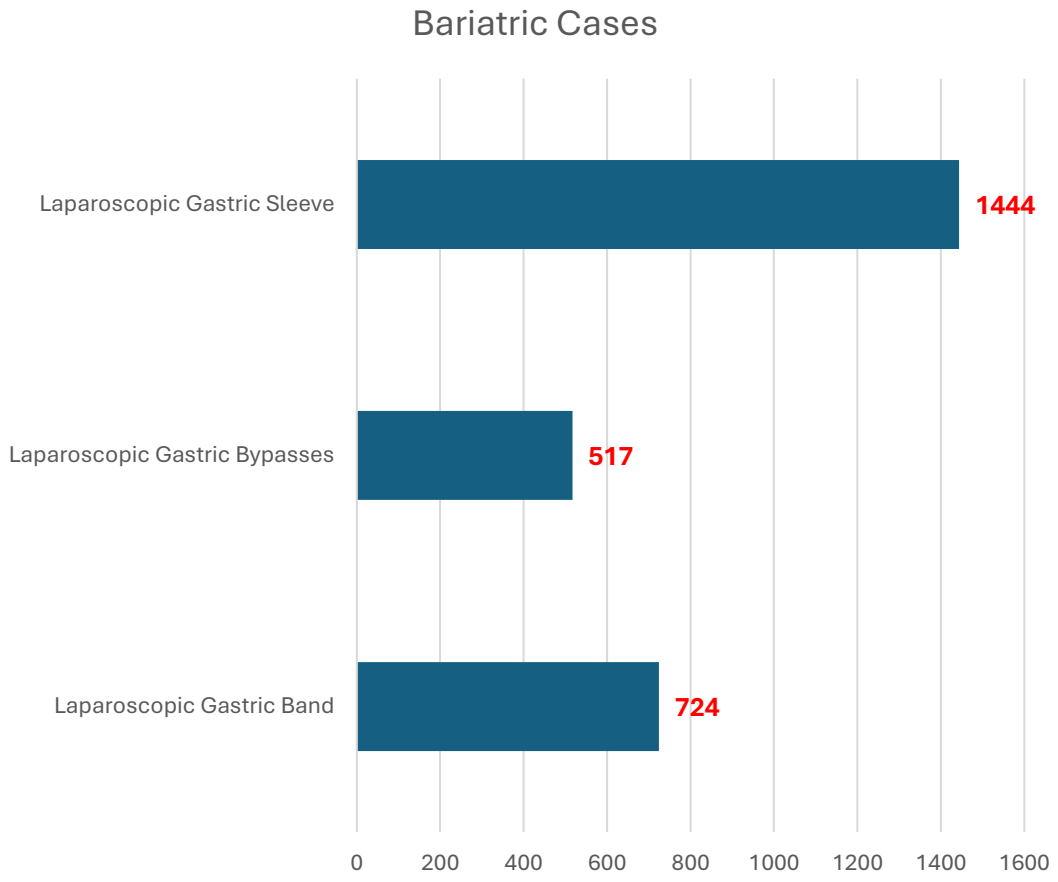
Disclosures

- No Conflicts of Interest
- Faculty for Ethicon Surgical
- 3000 Bariatric Cases
- 20% Revisional



Successful Revsional Surgery

Identifying Reliable Landmarks to Define Anatomy

The Hiatus

- CRUCIAL
- Provides *sequential* landmarks for all upper gastric anatomy
- It leads to everything else
  - Correct mobilisation and identification of GOJ / Angle of His
  - Complete mobilisation of fundus
  - Restore normal anatomy → proceed with revision
- Detection and correction of hiatal hernia (often “hidden”)

Always Dissect The Hiatus

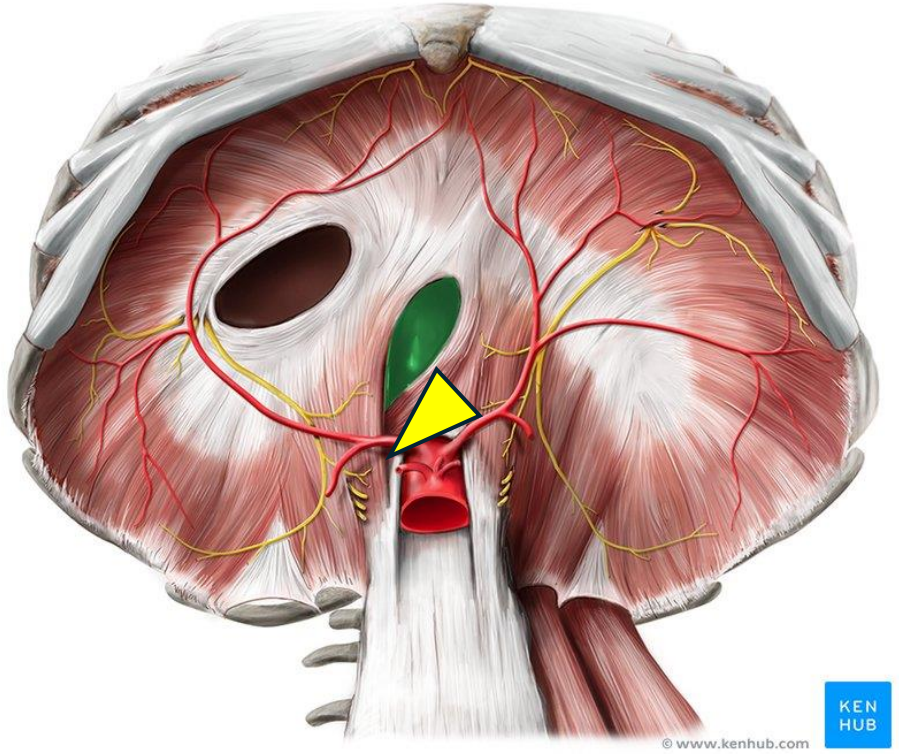
(well almost always)

Secrets To Revisional Surgery

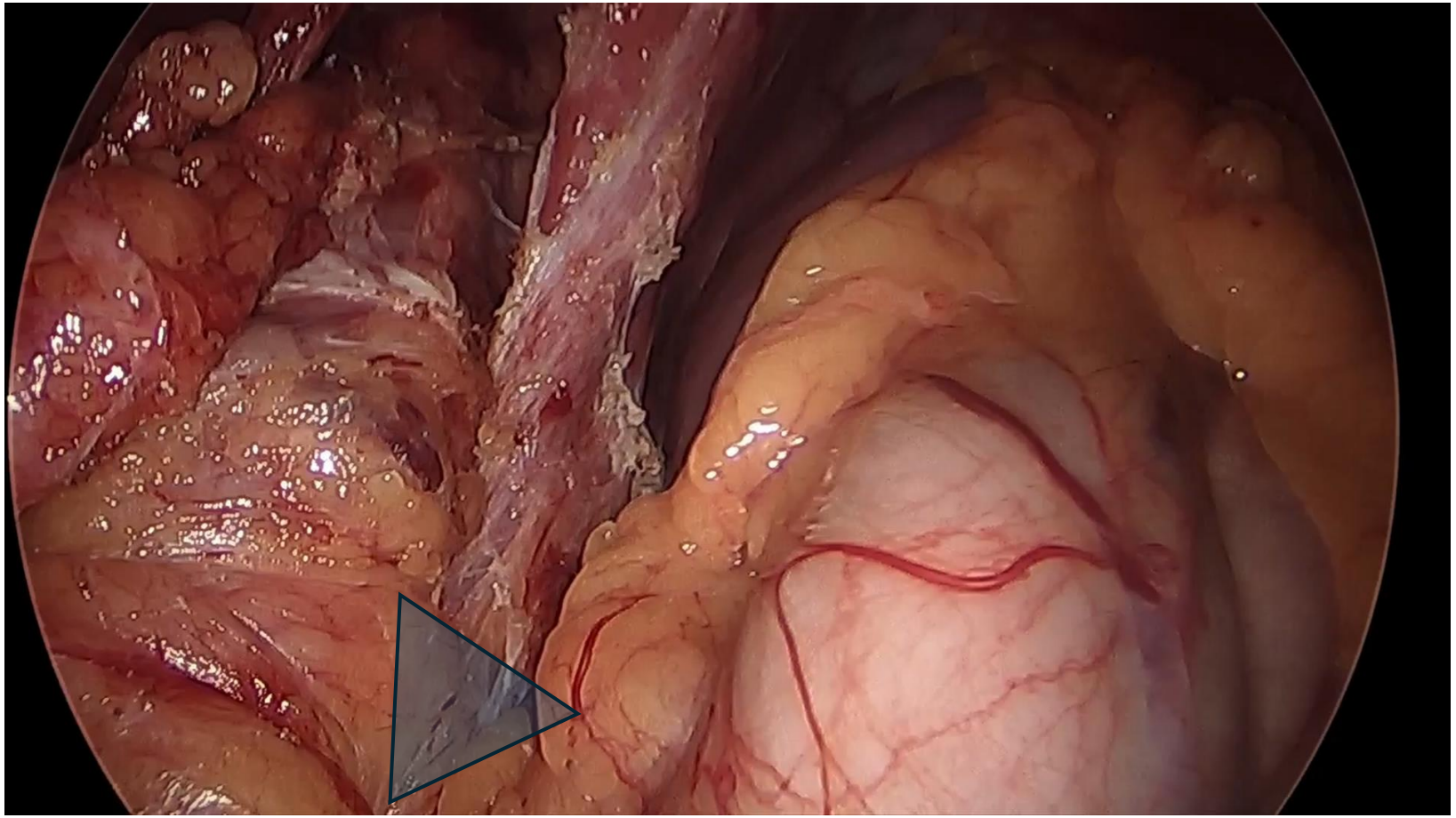
- The KEY to all Revisional Surgery Is ….

….. The Right Crus

- Avoids the “tiger country” of left crus / angle of His



Upper GI (Aly's ☺) Triangle



Tiger Country

- *The Upper GI Triangle Is The Danger Zone In Revisional Surgery*

- Confluence of….
  - Left Crus Base
  - Oesophagus / GOJ
  - Medial Fundus
  - Omental Adhesions
  - Gastro-Gastric Folds
  - Short Gastric Vessels
  - “Sac” from HH / Band Slippage
  - Liver

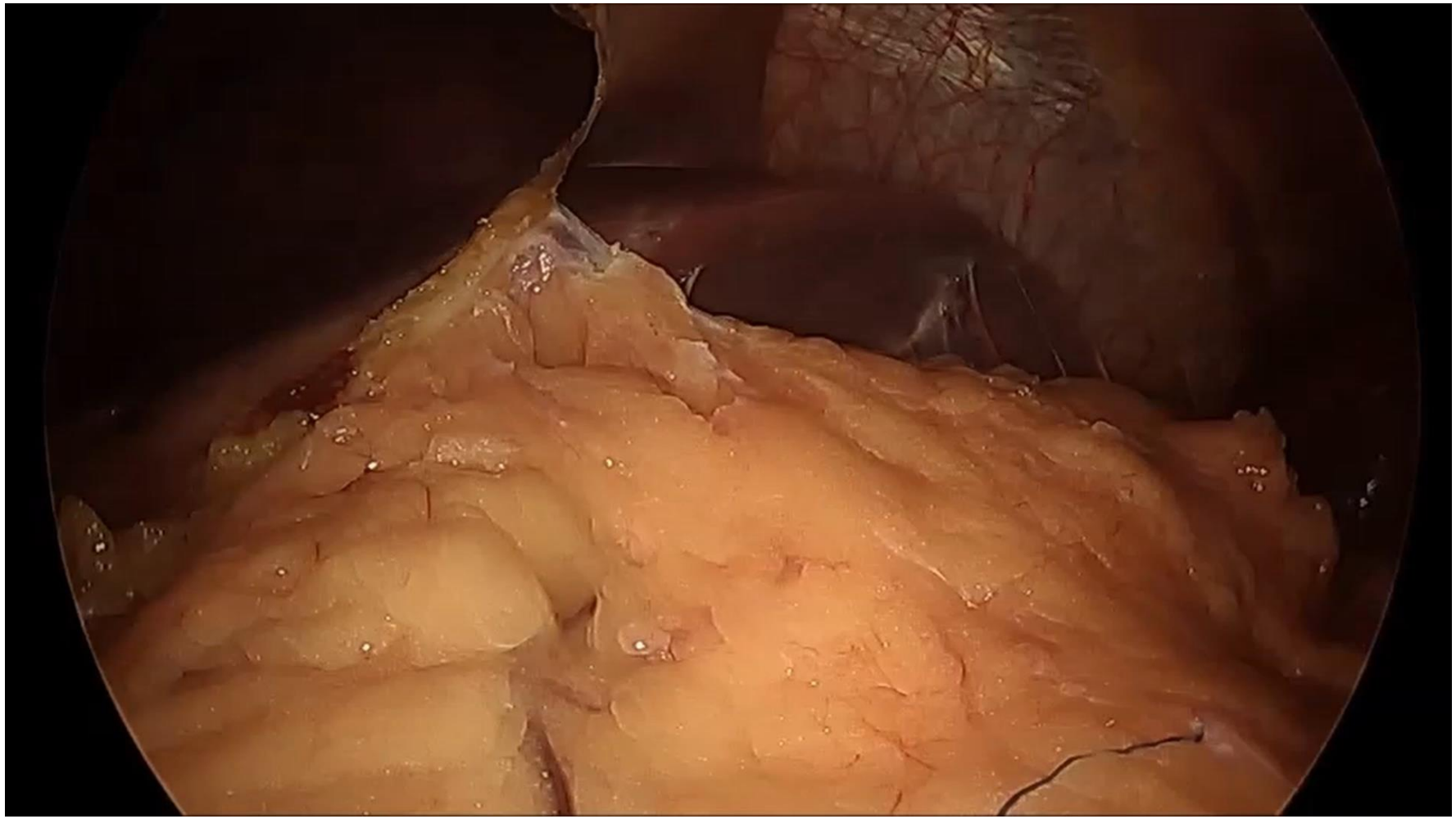
It’s Like A Vortex

…. everything gets sucked down onto this point.

Technical Tips – Dissecting The Hiatus

- Mediastinal Dissection Of The Crura
  - Provides landmarks for subsequent adhesional dissection
- “Lateralised” Oesophageal Mobilisation
- ROM (Retro-Oesophageal Manoeuvre)
  - Lifts posterior vagus
  - Negotiates difficult left crual adhesions

Technical Tips - The Right Crus

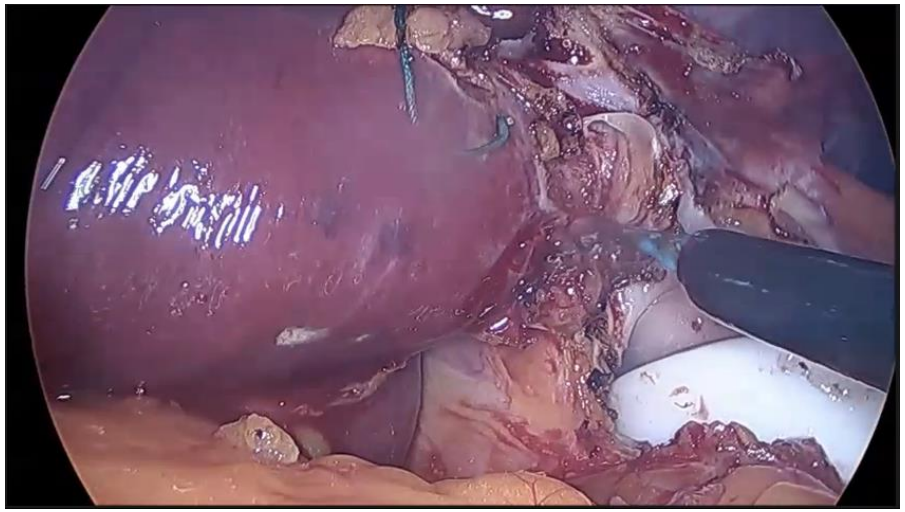


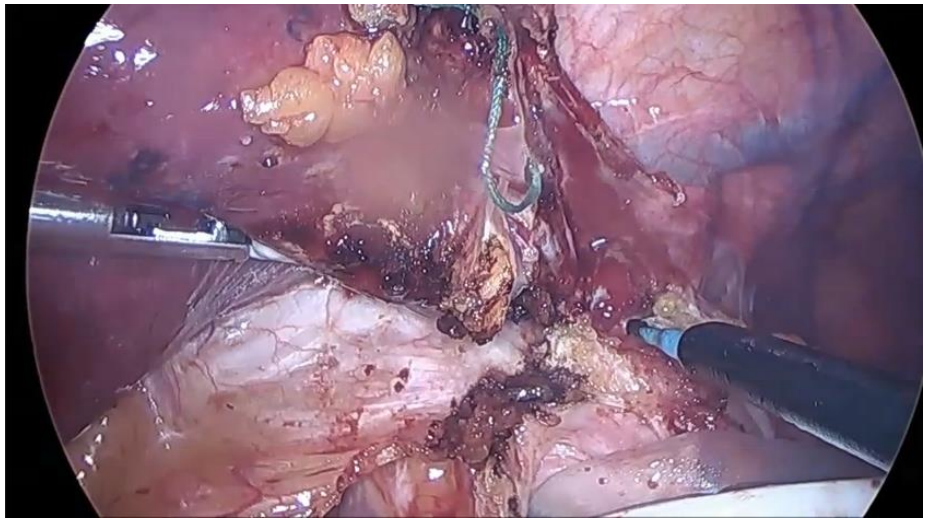
Beware / Tips

Beware The Accessory Left Hepatic

- Often pulled up by adhesions toward diaphragm
- Hidden between caudate and left lobe

➢ *Follow the right crus*





Beware / Tips

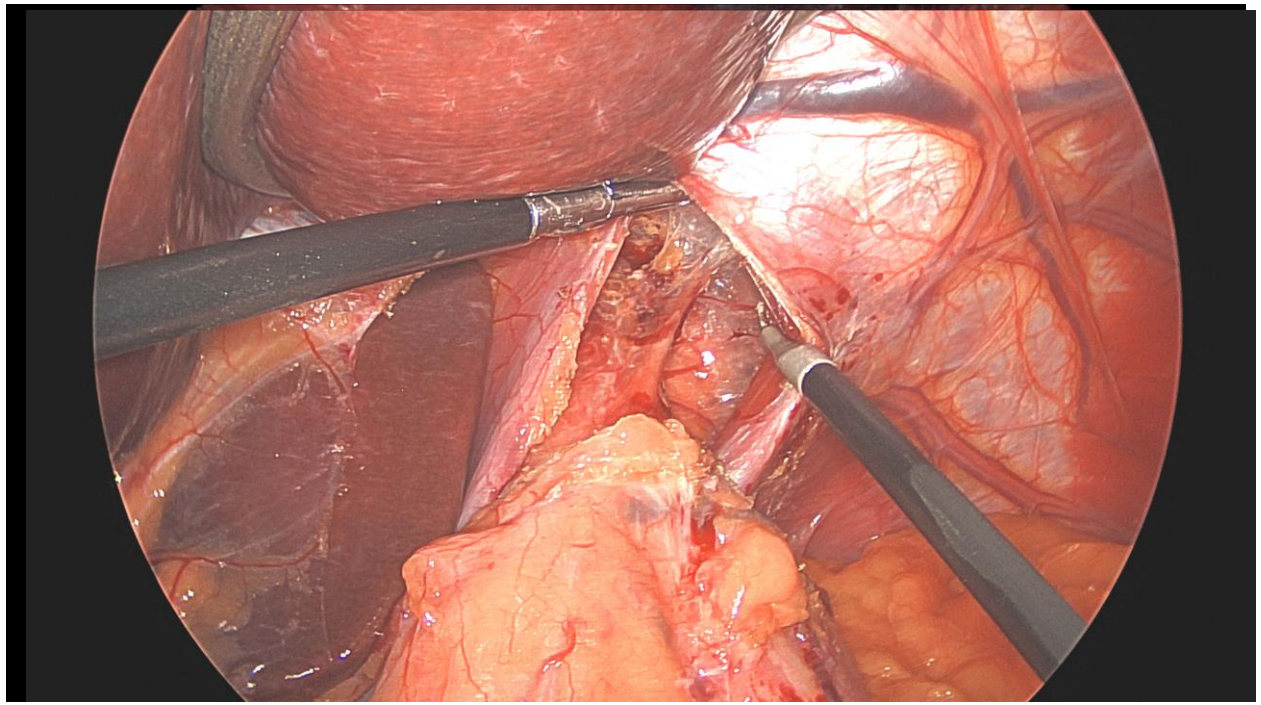
Beware The Left Gastric Artery

- Can be pulled out of position
- Can lie on the left crus

Technical Tips – Lateralised Mediastinal Mobilisation

Avoiding The Vagus & Oesophageal Injury

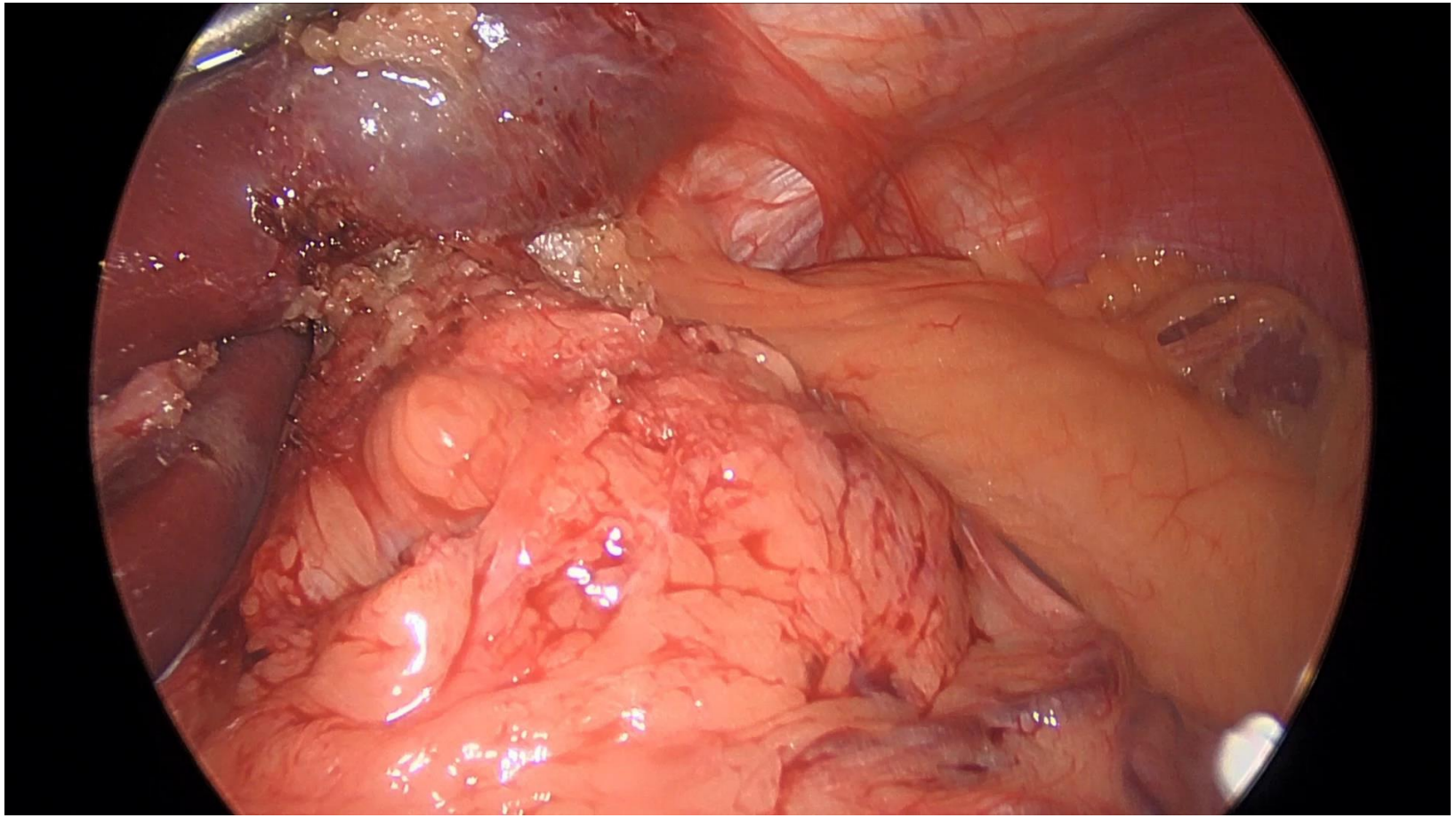
- Stay in the pericardial fat at apex of hiatus
- Stay on the internal aspect of the left crus
- Stay on the aorta (posterior vagus)



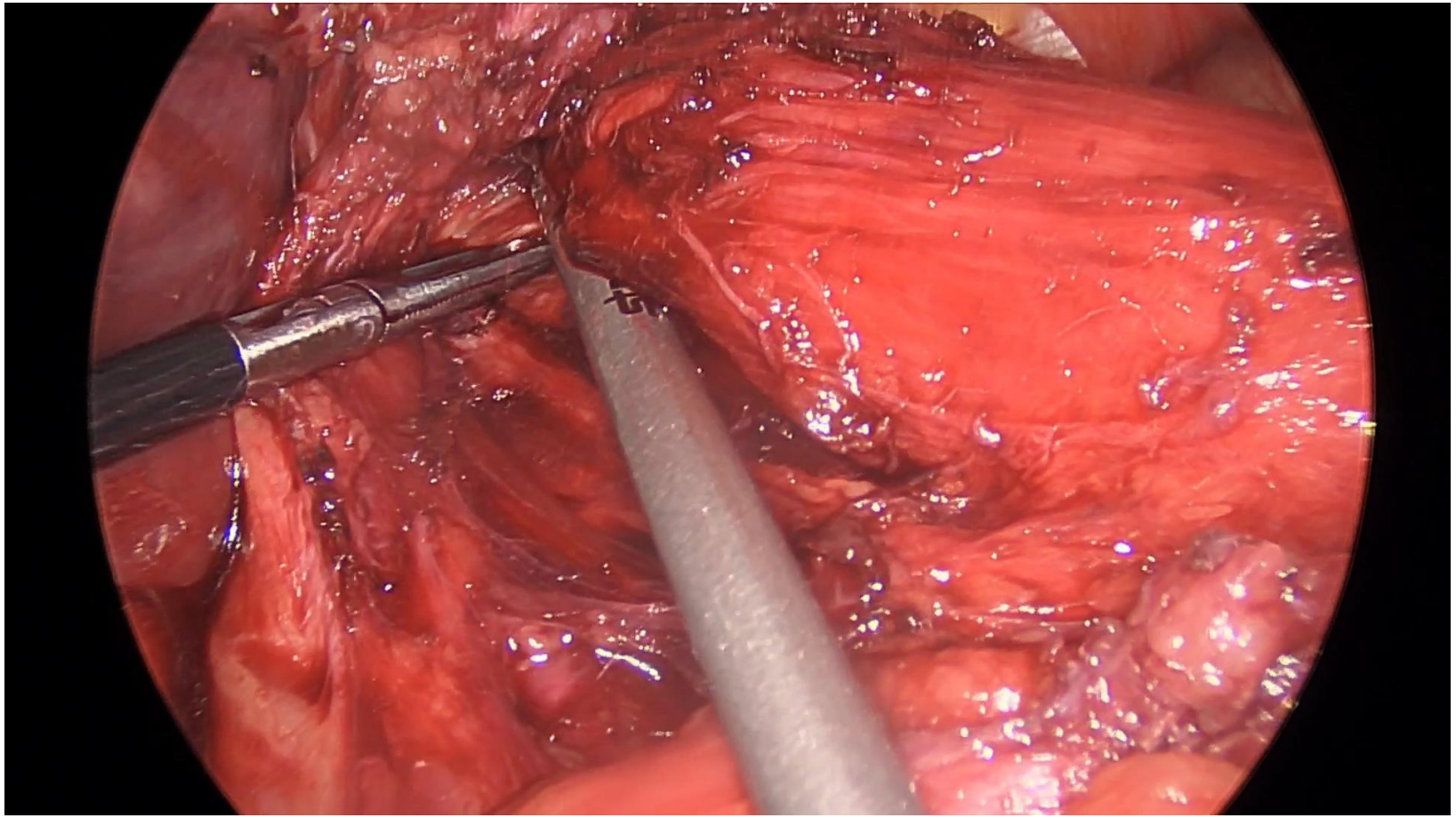
Difficulties

- Blunt dissection mostly
- Small venous bleeding → pack / haemostatic agents
- Pleural adhesions → breach
  - Let anaesthetist know
  - Usually self resolving (CO_2)
  - Repair large defects

Hidden Hernia



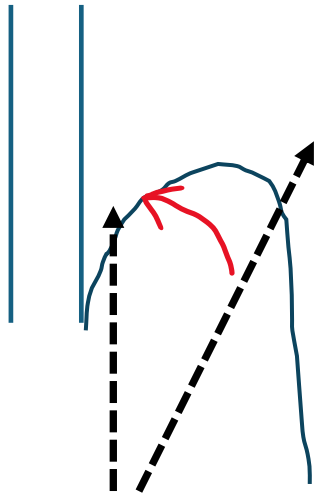
Technical Tips - ROM



Technical Tips - “Sleeve” Approach

Difficult Fundus

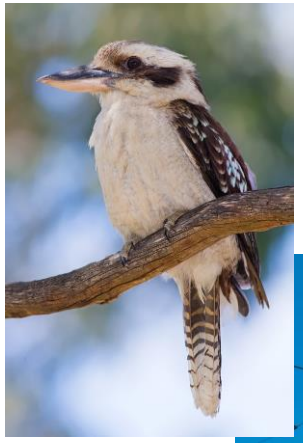
- Severe posterior tethering at Upper GI Triangle
- Take stapler laterally
- Then reflect fundus and mobilise from lateral side



Summary

In Revisional Surgery

- Always dissect the hiatus
- The right crus is the key that opens all the anatomy
- Dissect inside the crura to define landmark of left crus
- Stay wide and high in mediastinal mobilisation of oesophagus
- “ROM” can help in difficult left crus triangles



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