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ORIGINAL ARTICLE – GASTROINTESTINAL ONCOLOGY

# Three Trocars Laparoscopic Total Gastrectomy + D2 Lymphadenectomy with Intracorporeal Manual Esojejunostomy

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## ABSTRACT

**Background.** Minimally invasive surgery (MIS) is proved to be feasible and safe oncologically. In the past decade, a new philosophy of MIS, reducing abdominal trauma and improving the cosmetic results, has been popularized.[1–3] The authors report a three trocars laparoscopic total gastrectomy + D2 lymphadenectomy for lesser curvature gastric adenocarcinoma.

**Video.** A 52-year-old woman presenting a nondifferentiated gastric adenocarcinoma at the incisura angularis was admitted at consultation. Preoperative workup showed a T3N+M0 tumor. After neoadjuvant chemotherapy, laparoscopy was scheduled. Three trocars (5, 12, 5 mm) were placed in the abdomen. The operative field's exposure was improved by temporary percutaneous sutures. En bloc total gastrectomy and omentectomy was performed with a D2 lymphadenectomy, including the nodes of the stations 1, 2, 3, 4, 5, 6, 7, 8a, 8p, 9, 10, 11p, 11d, and 12a. Completely manual end-to-side esophago-jejunal anastomosis (Fig. 1a, b) and linear mechanical side-to-side jejuno-jejunal anastomosis were realized with the closure of both mesenteric and mesocolic defects. The specimen was retrieved through a suprapubic access.

**Results.** Operative time was 4 hours and 45 minutes (anastomosis: 30), and perioperative bleeding was 100 cc.

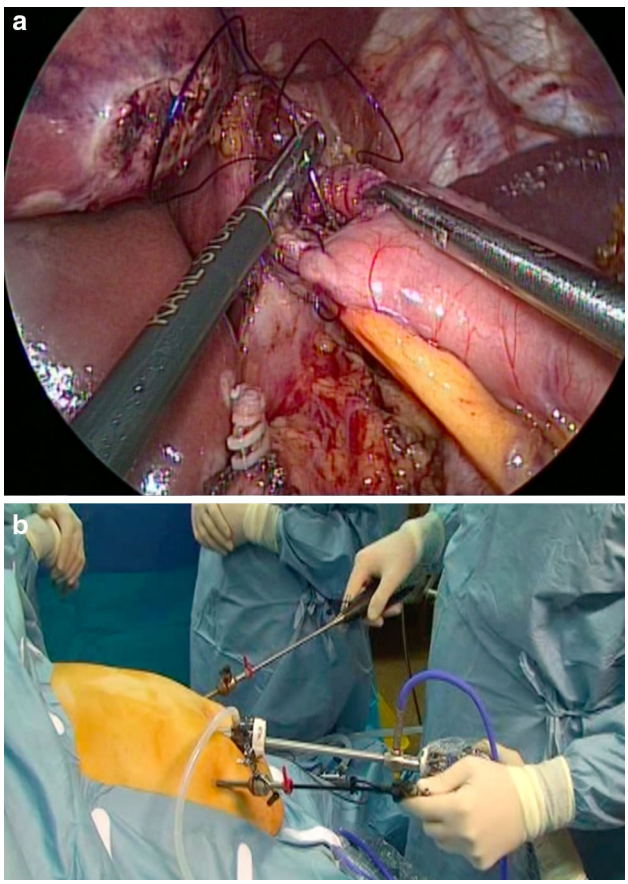


**FIG. 1** Esophago-jejunal anastomosis (**a**) performed by reduced port laparoscopic surgery (**b**)

Presented as video at the Annual Clinical Congress of the American College of Surgeons, Chicago, IL, October 4-8, 2015.

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Pathologic report confirmed nondifferentiated adenocarcinoma, mucinous, G3, infiltrating entirely the gastric wall, with 63 (4 positive) nodes removed; 7 edition UICC stage: pT4aN2aM0; keratine AE1/AE3 negative, HER2/neu, and HER2/CEP17 nonamplified. During postoperative follow-up, no recurrence was detected after 2 years.

**Conclusions.** Reduced port laparoscopic surgery provides the same quality of oncologic surgery as conventional multitrocar laparoscopy with added superior cosmesis and reduced abdominal trauma.

**DISCLOSURE** The other authors have no conflicts of interest or financial ties to disclosure regarding this video.

## REFERENCES

1. Dapri G. Himpens J, Cadière GB. Laparoscopic total gastrectomy and D2 lymphadenectomy. *Ann Surg Oncol.* 2010;17:1605.
2. Inaki N. Reduced port laparoscopic gastrectomy: a review, techniques, and perspective. *Asian J Endosc Surg*. 2015;8:1–10.
3. Kashiwagi H, Kumagai K, Monma E, Nozue M. Dual-port distal gastrectomy for the early gastric cancer. *Surg Endosc*. 2015;29;1321–6.