Adjuvant chemotherapy after neoadjuvant therapy followed by surgery in ypT + N+ ESCC patients might improve the OS by reducing the distant metastasis. The consideration could be given to administration of adjuvant chemotherapy to ypT + N+ ESCC patients with tolerable conditions.

307. INGENUITY OF ESOPHAGOGASTRIC ANASTOMOSIS IN OUR DEPARTMENT -RECONSTRUCTED GASTRIC TUBE STUMP CLOSURE USING ENDO GIA RADIAL RELOAD
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Anastomotic leakage is one of the three major complications after esophagectomy and can lead to surgery-related death. In our department, the standard surgical procedure is to elevate the gastric conduit via the posterior mediastinal pathway, and end-to-side anastomosis using a circular stapler for the residual esophagus and gastric conduit. In this study, we will report our reconstruction method and ingenuity, since Linear stapler was changed to Endo GIA Radial Reload and better outcomes were delivered.

The lesser curvature of the gastric conduit stump is the site where blood flow is most reduced. When the gastric conduit stump is closed with Linear stapler, the blood flow may be further reduced, because the stapler on the lesser curvature of the gastric conduit and the stapler on gastric conduit stump intersect. Closing the gastric conduit stump using Radial Reload avoids the stapler intersect at the lesser curvature and the gastric conduit stump. In addition, since a natural curve is formed at the gastric conduit stump, the pressure applied to the gastric tube stump by coughing can be dispersed.

Nine patients have undergone this reconstruction method, and no anastomotic leakage has been observed.

It is important to constantly evaluate one’s own surgical technique, and in addition, since a natural curve is formed at the gastric conduit stump, the pressure applied to the gastric tube stump by coughing can be dispersed. Nine patients have undergone this reconstruction method, and no anastomotic leakage has been observed.

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We reported our reconstruction method and ingenuity, since Linear stapler was changed to Endo GIA Radial Reload and better outcomes were delivered.

308. RIGHT TOP PULMONARY VEIN IS A VENOUS ANOMALY OF WHICH SURGEONS SHOULD BE AWARE IN SUBCARINAL DISSECTION FOR RADICAL ESOPHAGECTOMY
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A right top pulmonary vein (RTPV) that crosses behind the right bronchus, is a variation of the superior posterior pulmonary vein in the right upper lobe. Damage of this vessel can lead to intraoperative bleeding, congestion of the posterior segment of the right upper lobe, and cardiac tamponade.

Subcarinal lymph node dissection is mandatory in radical esophagectomy for esophageal cancer, and the RTPV is an anomalous vessel of which surgeons should be aware.

A 70-year-old man underwent thoracoscopic esophagectomy for esophageal cancer (T3N1M0). An anomaly of the superior posterior pulmonary vein in the right lobe was recognized on preoperative computed tomography imaging. With simulation and intraoperative navigation using three-dimensional imaging (SYNAPSE VINCENT, Fuji Photo Film Co., Ltd, Tokyo, Japan) of the same view as that observed during the operation, radical subcarinal dissection could be performed with preservation of the RTPV.

Only 5 case reports have described the association of RTPV in esophagectomy. In review of the literature, the incidence of RTPV ranged from 0.28 to 9.3%, and its mean vascular diameter ranged from 7.0 mm to 2.2 mm, with the right superior pulmonary vein being a common inflow site. Our case in which the RTPV ran dorsal to the right main bronchus is very rare. In radical subcarinal dissection of esophagectomy in cases with RTPV, it is important to recognize the posterior pericardial plane and release the ventral fixation of these lymph nodes to free space for the back side.

Based on our review of the relevant literature, an RTPV larger than 4.5 mm should be noted in order to prevent injury and ligation should be avoided. The preoperative recognition of this abnormal vessel using 3D imaging was very useful for radical SCLN dissection during thoracoscopic esophagectomy.

309. ASSESSMENT AND MANAGEMENT AFTER CORROSIVE INGESTION: WHEN IS SPECIALIST CENTRE REFERRAL NEEDED? A 10-YEAR UK EXPERIENCE
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Corrosive ingestion injuries are rare but clinically significant events, potentially associated with high morbidity and mortality. Low case-volumes limits guideline development. We report the largest UK cohort of patients admitted consecutively to a UGI tertiary referral centre after caustic ingestion, over a period of 10 years. Clinical presentation, diagnostics and treatment modalities as well as short and long-term outcomes were analysed, to produce evidence and the recommendation for centralization of management only of severe injuries.

All adults treated following corrosive ingestion between 2010 and 2020 were included. Eighty-one patients were included, with an average follow-up of 5 years. Blood results, imaging and endoscopic findings were reviewed. Patients were stratified based on endoscopic findings. Emergency and delayed management was analysed along with short and long-term outcomes. Predictive value of early outcome indicators was investigated.

Patients with injuries ≤ Zargar 2A had long-term outcomes similar to the ones with negative endoscopic findings.

All fifteen patients suffering injuries Zargar ≥ 2B required ITU and four died (26.6%). All deaths occurred within 50 days of ingestion, had Zargar grade ≥ 3 and airway involvement.

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