557. AN EXPERIENCE OF LAPAROSCOPIC GASTRECTOMY AND FUNDOPPLICATION FOR A PATIENT WITH NEUROENDOCRINE TUMOR AND LARGE HIATAL HERNIA WITH UPSIDE-DOWN STOMACH

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The case of a neuroendocrine tumor arising from an upside-down stomach due to a large hiatal hernia is rare but occasionally encountered in clinical practice. As we experienced such a case and successfully treated by simultaneous laparoscopic distal gastrectomy and hernia repair with fundoplication, we here report our experience.

A 79-year-old woman was referred to our hospital with suspicion of a stomach submucosal tumor. Detailed examination revealed the submucosal tumor in diameter of 20mm located on the middle third of stomach, and the pathology of biopsy showed the positivity for Chromogranin-A and Synaptophysin. CT scan also demonstrated the large hiatal hernia with prolapsing the almost whole stomach and transverse colon to the left thoracic cavity. We diagnosed that as Rindi classification type III neuroendocrine tumor and complex esophageal hiatal hernia, and we planned laparoscopic distal gastrectomy and hernia repair with fundoplication.

Laparoscopy showed the prolapse of almost whole stomach and colon through the esophageal hilum to left thoracic cavity. We pull them back to abdominal cavity and divided the hernia sac at the level of hilum. After distal gastrectomy, we managed to close the enlarged esophageal hilum without using artificial mesh by suturing the crus of diaphragm. We added the Toupet fundoplication to remnant stomach, and reconstructed the digestive tract by means of Roux-en-Y method. There were no findings of passage obstruction or regurgitation in the peroral contrast examination. The patient was discharged 7 days after surgery with good postoperative course.

Simultaneous laparoscopic gastrectomy and esophageal hiatus hernia repair was successfully performed. Enlarged esophageal hilum could be closed without using the artificial mesh even for the patient with an upside-down stomach, and Toupet fundoplication could be added for a small remnant stomach after distal gastrectomy. Therefore, our procedure was considered to be a safe and feasible minimally invasive surgery for such patients.

558. SURVIVAL IMPACT OF CLINICAL AND NONCLINICAL REASONS FOR DELAY TO ESOPHAGECTOMY AFTER NEOADJUVANT CROSS THERAPY

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The optimal time interval between completion of standard-of-care neoadjuvant CROSS chemoradiation and esophagectomy (CRT-S) in patients with esophageal cancer remains controversial. Precise reasons for prolongment of this interval are not well described, although studies have associated a prolonged CRT-S with variable survival outcomes. We aimed to evaluate whether specific reasons for delay to esophagectomy beyond the recommended period of 8 weeks post-chemoradiation are associated with differences in overall survival (OS).

A prospectively maintained database was reviewed for patients with esophageal cancer at a single academic institution who completed neoadjuvant CROSS therapy and underwent subsequent esophagectomy from 2012 to 2019. Patients were grouped by time interval of CRT-S into a no-delay group (≤56 days) and delay group (>56 days). The delay group was then further stratified by clinical and nonclinical reasons for delay. Demographics, comorbidities and complications were compared. A multivariable Cox regression model was used to evaluate the impact of variables on OS from time of surgery. Survival outcomes were described using standard Kaplan-Meier curves.

Of 96 patients, 48 (50.5%) had delays, with 62.5% (n=30) being for nonclinical reasons. Post-operative complications were similar between the no-delay and delay subgroups, except that the clinical delay group had more unplanned intensive care unit admissions (p=0.010) while clinical delay was not significantly different (p=0.968) from the no-delay group.

Patients with delay to esophagectomy greater than 8 weeks for nonclinical reasons after completion of chemoradiation had improved survival compared to patients undergoing esophagectomy within 8 weeks or who had delayed surgery for clinical reasons. Delay for nonclinical reasons was not associated...