

**24th NATIONAL CONGRESS OF SURGERY
ABSTRACTS**

VIDEO PRESENTATIONS

[V-002]**Technical details of laparoscopic cystostomy, unroofing and omentopexy in a giant hepatic hydatid cyst**

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Objective: Hydatid disease is a parasitic infection frequently encountered in endemic regions. It most commonly involves the liver, and its management varies according to cyst type, anatomical location, size, associated complications and surgical expertise. In this video presentation, we aimed to present our laparoscopic surgical approach in a case of a giant hepatic hydatid cyst.

Material and Methods: A 69-year-old male patient was evaluated due to elevated liver function tests and hyperbilirubinemia. Intravenous contrast-enhanced abdominal computed tomography (CT) and liver magnetic resonance imaging (MRI) revealed a 95×50 mm giant hydatid cyst located in segment VI of the liver, along with concomitant cholelithiasis. The patient underwent laparoscopic cystostomy, unroofing, cholecystectomy and omentopexy.

Results: A 69-year-old male with elevated liver enzymes (ALT 541 U/L, AST 354 U/L, GGT 624 U/L, ALP 121 U/L, total bilirubin 3.38 mg/dL) and a history of hypertension, diabetes mellitus, congestive heart failure, and vertigo was evaluated. Imaging revealed a 95×50 mm hydatid cyst in liver segment VI, not clearly classifiable by Gharbi criteria. IHA was positive (1/640). After three cycles of albendazole and unsuccessful PAIR, elective laparoscopic surgery was performed. Using one 10 mm umbilical and two 5 mm trocars, a 10 cm cyst adherent to the omentum and adjacent to the duodenum and transverse colon was identified. After careful adhesiolysis and placement of saline-soaked pads, the cyst was punctured, injected with hypertonic saline, and aspirated in three cycles. Cystostomy and unroofing were performed, and daughter vesicles, germinative membrane, and purulent material were removed. The cyst wall near the duodenum was preserved. No biliary communication was observed; a pedicled omental flap was placed and sutured (omentopexy). A subhepatic Jackson-Pratt drain was inserted. The postoperative course was uneventful, with drain removal on day 3 and discharge without complications.

Conclusion: In cases of giant hepatic hydatid cysts, the laparoscopic approach offers the well-established advantages of minimally invasive surgery and can be safely and effectively performed in experienced centers. Our video presentation demonstrates the feasibility and efficacy of laparoscopic cystostomy, unroofing and omentopexy in the management of hepatic hydatid cyst disease.

Keywords: Hydatid cyst, omentopexy, unroofing

[V-003]**Demonstration of an aberrant bile duct: Benefit of consistency in surgical technique**

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Objective: Anatomical variations of the extrahepatic biliary tree, particularly aberrant right hepatic or right segmental hepatic ducts, pose a significant risk for bile duct injury during laparoscopic cholecystectomy. Low insertion of an aberrant duct into the cystic duct is a rare but critical finding, as it can be inadvertently transected during the standard approach to Calot's triangle if not identified.

Material and Methods: Our patient underwent laparoscopic cholecystectomy for symptomatic cholelithiasis. During dissection to obtain the critical view of safety, the operating surgeon identified an additional tubular structure lying deep to the presumed cystic duct, partially obscured by fatty tissue. Initial appearance suggested an aberrant duct coursing toward the cystic duct at a low level. Careful and deliberate dissection of Calot's triangle was undertaken to delineate the anatomy. Further exposure confirmed that the additional structure was an aberrant right segmental hepatic duct joining the cystic duct at a low insertion point. The normal cystic duct and cystic artery were subsequently identified and skeletonized. No evidence of biliary injury occurred, and the aberrant duct was preserved intact.

Results: The procedure was completed without complication. The patient's postoperative recovery was uneventful, with no evidence of bile leak or other morbidity. Aberrant right hepatic or right segmental ducts with low insertion into the cystic duct are rare but surgically significant. Unrecognized, they are a major cause of bile duct injury, particularly during laparoscopic cholecystectomy.

Conclusion: This case highlights the importance of careful dissection within Calot's triangle, strict adherence to the critical view of safety, and maintaining a high index of suspicion for variant anatomy. Intraoperative cholangiography or near-infrared fluorescent cholangiography should be considered when ductal anatomy is uncertain.

Keywords: Critical view of safety, aberrant right bile duct, cholecystectomy

[V-004]

A giant progressive hepatic cyst mimicking biliary cystadenoma: Diagnostic challenges and laparoscopic management

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Objective: Hepatic cystic lesions are usually benign; however, progressive enlargement and atypical imaging features may raise suspicion for premalignant entities such as biliary cystadenoma. This case report aims to present the diagnostic course and laparoscopic management of a giant hepatic cyst that demonstrated progressive growth over time and radiological features mimicking biliary cystadenoma.

Material and Methods: Clinical data, serial imaging findings, and surgical outcomes of a 77-year-old female patient were retrospectively reviewed. Ultrasonography examinations performed between 2023 and 2025 and a non-contrast computed tomography (CT) scan obtained in 2026 were analyzed to assess changes in lesion size, localization, and internal characteristics. Due to progressive enlargement, symptomatic presentation, and inability to establish a definitive radiological diagnosis, laparoscopic cyst unroofing was performed. Intraoperative findings, histopathological results, and postoperative follow-up data were evaluated. Preoperative CT images and intraoperative video recordings were prepared for oral presentation.

Results: In 2023, a thin-walled cystic lesion measuring 96×90 mm was detected in hepatic segments IVa-IVb-VII-VIII. Follow-up ultrasonography in 2025 demonstrated significant enlargement to 172×127 mm, with imaging features insufficient to differentiate between a simple hepatic cyst and biliary cystadenoma. In 2026, non-contrast CT revealed a giant cystic lesion measuring 200×170×133 mm, extending into both hepatic lobes and causing marked mass effect. The patient reported intermittent early satiety, nausea, and vomiting. Laparoscopic cyst unroofing was performed. Intraoperatively, bile crystals were observed within the cyst cavity; however, no active bile leakage was detected. Postoperative drain output showed no bile, and the drain was safely removed on postoperative day 10. Cytological analysis of the cyst fluid and histopathological examination of the resected cyst wall were consistent with a simple hepatic cyst.

Conclusion: Progressively enlarging hepatic cysts with atypical imaging features may present significant diagnostic challenges. In symptomatic patients with radiological uncertainty, laparoscopic cyst unroofing is a safe, effective, and minimally invasive approach that provides both therapeutic benefit and definitive diagnosis.

Keywords: Diagnostic challenge, giant liver cyst, hepatic cyst, laparoscopic surgery

[V-005]

Laparoscopic spleen-preserving distal pancreatectomy: Technical notes

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Objective: With the DIPLOMA study, minimally invasive distal pancreatectomy has been shown to provide long-term survival comparable to open surgery in patients with upfront resectable pancreatic cancer. When these findings are considered together with the general advantages of minimally invasive techniques—namely reduced postoperative pain, shorter hospital stay, and lower rates of complications such as incisional hernia—they suggest that this approach is progressing toward becoming the gold standard. Accordingly, the standardization of spleen-preserving techniques, particularly preferred for benign lesions and low-grade neuroendocrine tumors, has regained importance in the current era with the increasing adoption of minimally invasive surgery.

Material and Methods: A 29-year-old female patient undergoing examination by the endocrinology department due to hypoglycemic attacks was found to have a suspicious lesion measuring 11 mm in diameter in the tail of the pancreas, consistent with a neuroendocrine tumor. Considering her symptoms, the patient was evaluated in a multidisciplinary conference with a preliminary diagnosis of insulinoma, and it was decided to perform a spleen-preserving distal pancreatectomy.

Results: A laparoscopic spleen-preserving pancreatic tail resection was planned. The surgical procedure was performed using one 12 mm and three 5 mm trocars (Figure 1). The gastrocolic ligament was opened, and gastric retraction was performed by passing a 2/0 silk suture posteriorly. The pancreas was scanned with intraoperative ultrasound, and the lesion area was identified, revealing its relationship with the splenic vein. The inferior pancreas was freed using an ultrasonic energy device (MEDISONIC). Dissection continued posteriorly. The splenic artery was identified superiorly. The venous branches between the splenic vein and the pancreas were clipped and cut, and the splenic vein was dissected from the pancreatic tissue using hooks and an ultrasonic energy device, starting from the splenic hilum and running medially. After the splenic vein and artery were dissected from the pancreatic tissue up to the pancreatic transection line determined by intraoperative ultrasound, laparoscopic bulldog clamps were placed on the transection line and waited for 7 minutes to prepare the pancreatic tissue for transection. The pancreas was closed and cut using an EndoGIA (Medtronic) stapler. The specimen was removed through the Pfannenstiel incision inside the endobag. Hemopatch was applied to the pancreatic transection line and covered with Tisseel.

Conclusion: Minimally invasive techniques are strong candidates to become the standard treatment approach for left-sided pancreatic resections; detailed description and sharing of these techniques without compromising oncological principles will significantly contribute to increasing their safe and effective applicability by broader surgical communities.

Keywords: Laparoscopy, pancreatic surgery

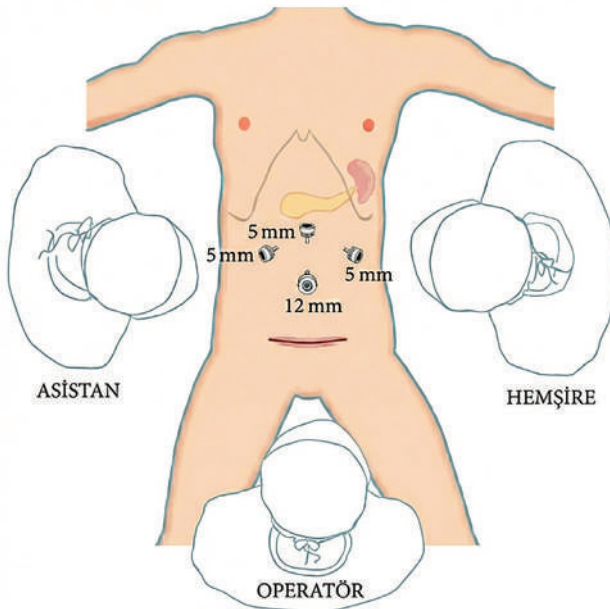


Figure 1. Trochar placement.

[V-006]

Liver surgery experience at University of Health Sciences Türkiye, Gaziantep City Hospital: Etiology, type of surgery, and survival outcomes

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Objective: Liver surgery carries high technical complexity and morbidity risk. Both benign and malignant liver diseases may require surgical intervention. This study aimed to analyze etiology, surgical procedures, and survival outcomes of patients who underwent liver surgery at University of Health Sciences Türkiye, Gaziantep City Hospital between 2023 and 2025.

Material and Methods: Thirty-five patients were retrospectively evaluated. Etiology was classified as benign or malignant; malignant cases were further divided into colorectal metastases, cholangiocarcinoma, and hepatocellular carcinoma (HCC). Surgical procedures included major and minor hepatectomies, combined hepatopancreatic surgery, biliary/hilar surgery, and other interventions. Some patients underwent additional procedures such as Whipple, low anterior resection (LAR), or right hemicolectomy. Survival was analyzed using Kaplan-Meier curves, and comparisons were performed with the log-rank test.

Results: A total of 35 patients were included, with the majority having malignant lesions. Colorectal metastases were the most frequent malignancy, followed by cholangiocarcinoma and HCC. Regarding surgical procedures, seven patients underwent right hepatectomy and six underwent left hepatectomy, while three patients each underwent left lateral segmentectomy, single segmentectomy, and atypical resections. Segment VII segmentectomy was performed in two patients, and laparoscopic segmentectomy in two. Two patients underwent simultaneous Whipple procedure, one underwent LAR, and another underwent right hemicolectomy. Major and minor hepatectomies were the most common surgeries. Kaplan-Meier

analysis showed no significant differences in survival between benign and malignant cases (log-rank $p=0.56$), between malignant subgroups (HCC vs. cholangiocarcinoma, $p=0.42$; colorectal metastases vs. other malignancies, $p=0.75$), or between surgical types (major vs. minor hepatectomy, $p=0.99$; major hepatectomy vs other procedures, $p=0.87$).

Conclusion: Liver surgery at our institution encompassed a wide spectrum of procedures, including major and minor hepatectomies, combined hepatopancreatic and biliary/hilar surgeries, and laparoscopic resections. Despite the complexity of these interventions, survival outcomes were similar across etiological and surgical subgroups. These findings suggest that, with appropriate patient selection and surgical expertise, liver surgery can be performed safely with comparable long-term outcomes, even in technically challenging cases.

Keyword: Liver resection

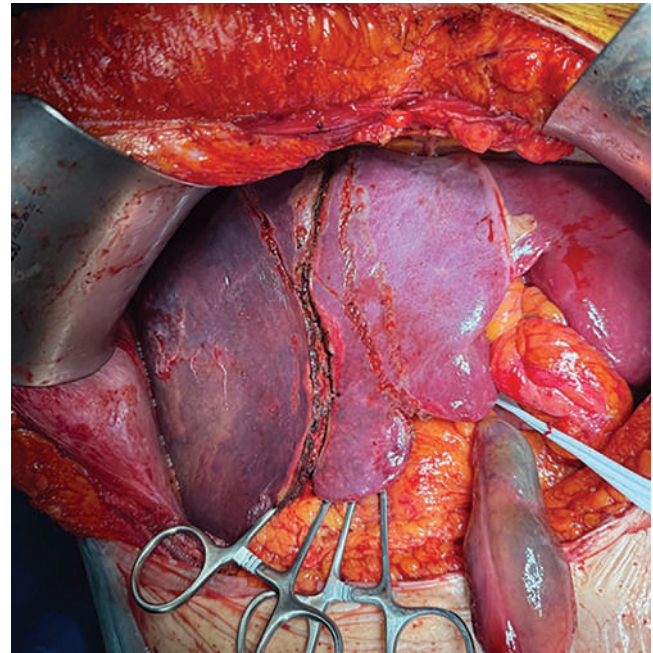


Figure 1. Line of demarcation.

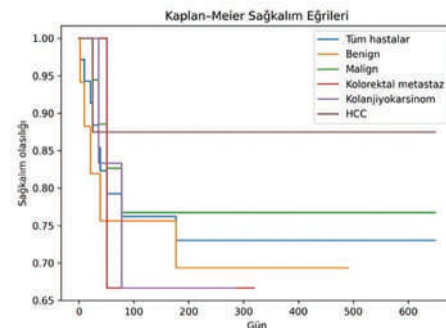


Figure 2. Kaplan-Meier survival curve.

[V-008]

Complex ventral hernia repair using botulinum toxin with combination of Fasciotens® after colorectal surgery: A video vignette

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Objective: Large incisional hernias following colorectal surgery remain a significant reconstructive challenge, particularly in elderly patients with marked fascial retraction and loss of abdominal domain. Achieving tension-free midline closure without extensive myofascial dissection is often difficult and associated with considerable morbidity.

Material and Methods: We present a video vignette demonstrating a combined approach using preoperative botulinum toxin A (BTA) injections and intraoperative dynamic fascial traction with the Fasciotens® device in a 75-year-old male with a giant midline incisional hernia following anterior resection for colorectal cancer. Four weeks prior to surgery, ultrasound-guided BTA was administered into the lateral abdominal wall muscles to induce chemical component relaxation, as previously described in complex hernia repair strategies. During surgery, controlled and symmetrical traction applied to both fascial edges using the Fasciotens® device enabled progressive medialization and primary midline closure without the need for anterior or posterior component separation. The procedure was completed safely, followed by mesh reinforcement.

Results: No intraoperative complications occurred, and the patient's early recovery was uneventful. Oral intake and mobilization were initiated on postoperative day one, and he was discharged with intact repair and no signs of respiratory compromise or abdominal hypertension on postoperative day five. The patient is currently in the second postoperative month; therefore, the follow-up period is not yet sufficient to fully evaluate outcomes.

Conclusion: This case highlights the feasibility of combining chemical and mechanical fascial elongation techniques to facilitate primary closure in selected patients with complex ventral hernias after colorectal surgery, potentially reducing the need for component separation.

Keywords: Botulinum toxin A, Fasciotens®, complex ventral hernia, abdominal wall reconstruction, colorectal surgery

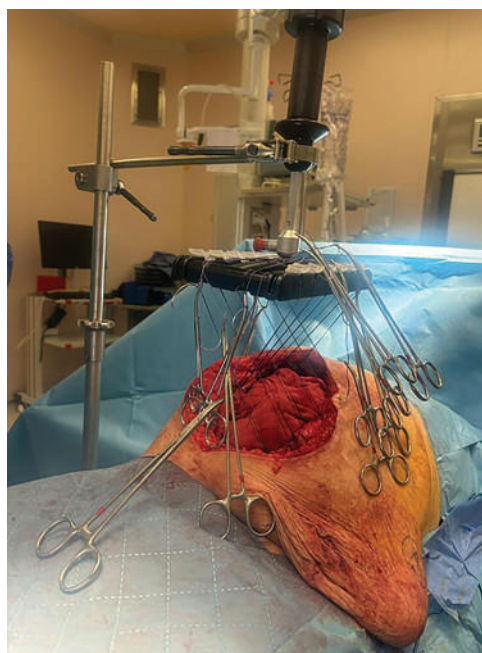


Figure 1. Fascial traction using the Fasciotens® device.

[V-010]

Laparoscopic (TAPP) approach in recurrent inguinal hernia after conventional and total extraperitoneal techniques

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Objective: Abdominal wall hernia repair methods can be performed using anterior or posterior approaches.

Material and Methods: Especially in cases of recurrence after surgery, choosing the correct method based on the initial surgery can be beneficial in terms of complications and physician-patient comfort.

Results: In almost all repair methods, the mesh used must cover all herniated disc areas in the myopectineal orifice.

Conclusion: In this case, we will share our experience with a laparoscopic (TAPP) approach in a patient who previously underwent open and total extraperitoneal repair but experienced recurrence in the right femoral region.

Keywords: Inguinal hernia, TAPP, TEP

[V-011]**Transabdominal preperitoneal (TAPP) repair of obturator hernia in an elderly patient: A case report**

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Objective: Obturator hernia is a rare but clinically significant entity, predominantly affecting frail, elderly women. Due to its deep pelvic location and non-specific clinical presentation, diagnosis is often delayed, frequently resulting in bowel obstruction and the need for emergency laparotomy. With advances in minimally invasive surgery, laparoscopic approaches—particularly the transabdominal preperitoneal (TAPP) technique—offer both diagnostic and therapeutic advantages. We present a case of obturator hernia successfully managed using a laparoscopic TAPP approach.

Material and Methods: An 88-year-old female presented with pain originating from the medial aspect of the left thigh and radiating to the leg and lower back. Her medical history included an exploratory laparotomy for perforation in 2016, Alzheimer's disease, vertigo, and hypertension. On physical examination, the abdomen was soft without tenderness or signs of peritoneal irritation. Pain increased with flexion of the left lower extremity. Laboratory parameters were within normal limits. Abdominopelvic computed tomography revealed a narrow-necked hernia sac at the level of the left obturator canal, extending between the pectineus and obturator externus muscles and containing an ileal loop. Proximal small bowel dilation with distal collapse was observed, consistent with partial obstruction. The patient was taken to emergency surgery. Under general anesthesia, a TAPP approach was performed. During laparoscopic exploration, the incarcerated bowel loop

was found to have spontaneously reduced. Pelvic fluid was aspirated and the operative field irrigated. The peritoneum overlying the defect was incised, the hernia sac was dissected, and a 10×10 cm polypropylene mesh was placed in the preperitoneal space and secured with tackers. The peritoneum was closed, and the procedure was completed. The postoperative course was uneventful. The patient was discharged on postoperative day three. No complications or recurrence were observed at the one-week follow-up. A narrow-necked hernia sac was identified at the level of the left obturator foramen, extending between the pectineus and obturator externus muscles and containing a segment of ileum (obturator hernia). Minimal free fluid densities suggestive of edema were observed within the hernia sac. This level constituted a transition zone; the small bowel loops proximal to the herniation (jejunum and proximal ileum) demonstrated dilatation up to 25 mm in maximal diameter with intermittent air-fluid levels, whereas the bowel loops distal to the hernia site were collapsed.

Results: No intraoperative complications occurred. Bowel viability was preserved, and no resection was required. Oral intake was initiated on postoperative day 1 and advanced gradually. The patient was discharged on postoperative day 3 without complications. At one-week follow-up, no postoperative morbidity or recurrence was observed.

Conclusion: Obturator hernia should be considered in elderly female patients presenting with medial thigh pain and non-specific abdominal findings. Early CT imaging enables timely diagnosis. In selected patients, laparoscopic TAPP repair provides safe intra-abdominal exploration, allows assessment of bowel viability, and facilitates secure preperitoneal mesh placement with minimal morbidity. TAPP may represent an effective minimally invasive alternative to open surgery in obturator hernia management.

Keywords: Laparoscopic surgery, obturator hernia, transabdominal preperitoneal repair (TAPP)

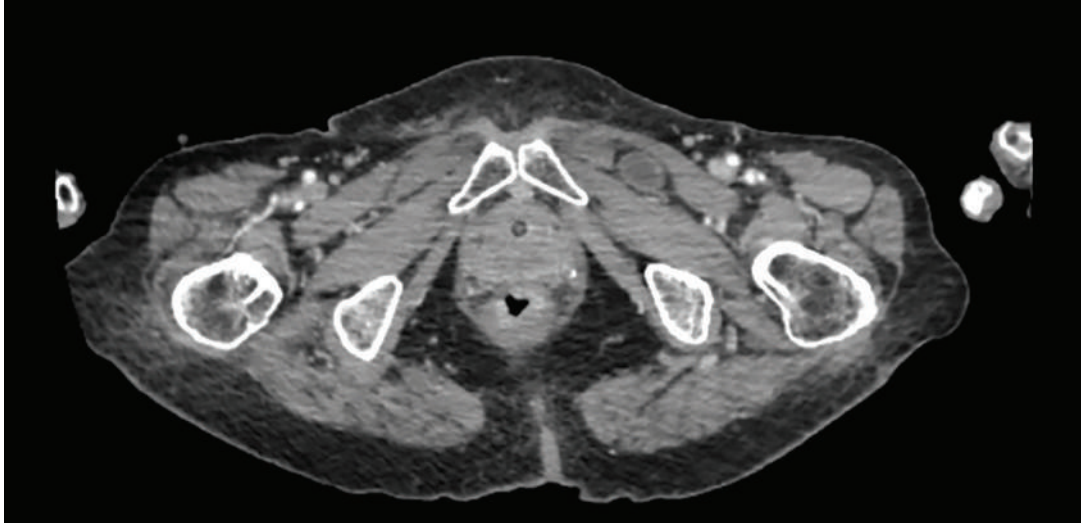


Figure 1. Abdominopelvic CT showing left obturator hernia with proximal small bowel dilatation.

[V-013]**eTEP repair of incisional herni, case presentation**

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Objective: Incisional hernia is a common complication following abdominal surgery and may significantly impair quality of life. With advances in minimally invasive surgery, the extended totally extraperitoneal (eTEP) approach has emerged as a novel technique that enables laparoscopic retromuscular hernia repair. The aim of this study is to present the surgical technique and early clinical outcomes of an incisional hernia case repaired using the eTEP approach.

Material and Methods: A 38-year-old female patient presented to our clinic with a symptomatic incisional hernia that developed at the site of a previous abdominal surgery. The diagnosis of incisional hernia was confirmed by physical examination and imaging studies. Laparoscopic eTEP incisional hernia repair was planned. During the procedure, the retromuscular space was accessed, the posterior rectus sheath was dissected, and the hernia sac was reduced. The right and left retromuscular spaces were connected. After primary closure of the posterior fascia, a mesh with adequate overlap was placed in the retromuscular space. The intraperitoneal cavity was not entered during the operation.

Results: The surgical procedure was completed successfully without any intraoperative complications. Operative time and blood loss were within acceptable limits. In the postoperative period, the patient was mobilized early, and oral intake was resumed shortly after surgery. Postoperative pain was mild and adequately controlled with minimal analgesic requirements. No early postoperative complications such as seroma, hematoma, surgical site infection, or recurrence were observed. The patient was discharged after a short hospital stay and remained clinically stable during early follow-up.

Conclusion: The eTEP approach is a safe, effective, and anatomically sound minimally invasive technique for the repair of incisional hernias. By avoiding intraperitoneal mesh placement, this method may reduce the risk of bowel injury, adhesion formation, and chronic postoperative pain. With appropriate patient selection and sufficient surgical expertise, the eTEP technique represents a strong and promising alternative in the management of incisional hernias.

Keywords: eTEP, extended totally extraperitoneal, laparoscopic incisional hernia, minimal invasive surgery



Figure 1. CT scan of incisional hernia wide incisional hernia.



Figure 2. CT scan of incisional hernia wide incisional hernia.



Figure 3. CT scan of incisional hernia wide incisional hernia.

[V-014]**Abdominal wall reconstruction with robotic e-TEP-TAR and concomitant inguinal hernia repair in a post-transplant complex incisional hernia**

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Objective: Complex incisional hernias, particularly those involving multiple defects along a wide incision line, represents significant surgical challenges. In these patients, adhesions, alterations in tissue quality, and the presence of concomitant hernias complicate operative planning. The robotic enhanced-view totally extraperitoneal (eTEP) approach combined with transversus abdominis release (TAR) enables extensive dissection within the retromuscular plane and secure mesh placement. In this video, we present the robotic eTEP-TAR repair of complex incisional hernia with concomitant inguinal hernia in a post-transplant patient.

Material and Methods: An 84-year-old male presented with abdominal and left groin swelling. His medical history included prior umbilical hernia repair and liver transplantation. Multiple fascial defects along a previous Mercedes incision and a left direct inguinal hernia were identified. Due to the complexity of the abdominal wall defects, robotic extended totally extraperitoneal transversus abdominis release (e-TEP-TAR) repair was planned.

Results: The patient was positioned supine. Three 8-mm robotic trocars were placed under direct vision into the preperitoneal retromuscular plane lateral to the right rectus sheath along the midclavicular line. Dissection began in the right lower quadrant, preserving the posterior sheath, and the retromuscular plane was developed across the linea alba to the contralateral side. The left rectus sheath was incised, and dissection was advanced toward the inguinal region. A left direct inguinal hernia and additional lower quadrant defects were identified and reduced. After completing bilateral retromuscular and preperitoneal dissection, a transversus abdominis release (TAR) was performed to achieve adequate medialization, extending the dissection laterally into the retroperitoneal space. For right upper quadrant access, three additional 8-mm trocars were placed lateral to the left rectus sheath, and the robot was redocked. Incisional hernia defects related to the previous Mercedes incision were reduced bilaterally and along the midline, with the hernia sac dissected up to the xiphoid process. The left inguinal hernia was repaired using a 12×17 cm mesh. Fascial defects in the lower quadrant and epigastric region were primarily closed with 3/0 V-Loc, and peritoneal defects were closed with 3/0 Vicryl. A 30×30 cm polypropylene mesh was placed to retromuscular plane and secured with 3/0 Vicryl. An additional 12×17 cm mesh was positioned to reinforce the right lower quadrant.

Conclusion: The robotic eTEP-TAR approach provides an effective method for abdominal wall reconstruction by allowing wide retromuscular workspace in complex incisional hernias. While preserving the advantages of minimally invasive surgery, this technique represents an alternative in the management of complex abdominal wall defects.

Keywords: Robotic surgery, incisional hernia

[V-015]**Robotic-assisted surgical treatment of achalasia**

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Objective: Achalasia is a rare primary esophageal motility disorder characterized by insufficient relaxation of the lower esophageal sphincter (LES) during swallowing and the loss of peristalsis in the esophageal body. Patients typically present with symptoms such as dysphagia, regurgitation, chest pain, and weight loss. Currently, Heller myotomy, which is the gold standard in surgical treatment, is successfully performed using minimally invasive techniques. Robotic surgical systems offer significant advantages to the surgeon, particularly in areas requiring narrow and deep dissection such as the esophagus, by providing three-dimensional high-resolution imaging and superior maneuverability. In this presentation, the clinical course and outcomes of an achalasia case treated with a robotic approach are discussed.

Material and Methods: A 27-year-old male patient presented to our clinic with complaints of dysphagia during meals and nocturnal regurgitation that woke him from sleep, which had been ongoing for approximately 6 months. No additional systemic diseases were identified in the patient's medical history. Diagnostic gastroscopy revealed a dilated esophageal lumen and the presence of tertiary contractions. It was observed that the lower esophageal sphincter could only be passed with difficulty. In radiological evaluations, thoracic computed tomography (CT) showed significant esophageal dilatation starting from the level of the thoracic inlet, reaching a transverse diameter of 4 cm in the middle segment. The same imaging identified diffuse thickening of the lower esophageal sphincter (LES) and a "pencil-tip" narrowing in the distal esophagus. A contrast esophagram confirmed the typical "bird's beak" appearance, which is pathognomonic for achalasia.

Results: Robotic Heller myotomy was planned for the patient whose diagnosis of achalasia was confirmed based on clinical and radiological findings. During the procedure, the patient was placed in the supine position. The robotic system was docked via four 8-mm trocars placed transversally at the level of the umbilicus. The esophagogastric junction was mobilized with the precision provided by robotic dissection, and the myotomy was performed. Mucosal integrity was meticulously preserved during the procedure. No complications occurred during the postoperative follow-up period. A swallow study performed on the first postoperative day revealed that the contrast medium passed freely into the stomach without stasis in the esophagus, and the passage was fully patent. The patient, whose symptoms had completely resolved, was discharged in good health.

Conclusion: The robotic approach in achalasia surgery offers lower risks of mucosal perforation and provides a more ergonomic working environment for the surgeon compared to conventional laparoscopy. In particular, the "wristed" maneuverability of robotic instruments enhances depth control during the precise myotomy of the lower esophageal sphincter (LES). This case demonstrates that robotic Heller myotomy is a reliable and effective method for achieving symptomatic improvement in young patients.

Keywords: Achalasia, dysphagia, heller myotomy, robotic surgery

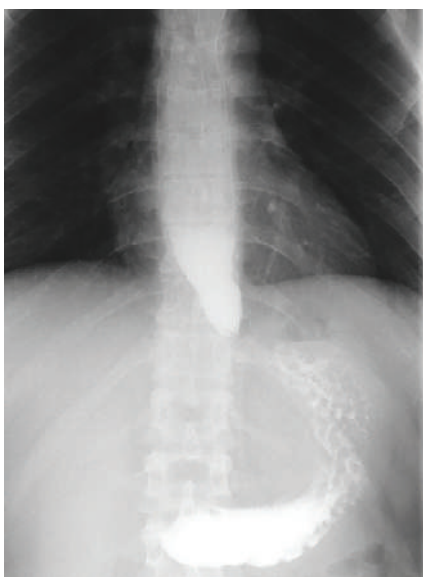


Figure 1. Preoperative barium esophagram.

[V-016]

Robotic pylorus-preserving pancreaticoduodenectomy

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Objective: Pancreaticoduodenectomy (PD) has been accepted as the gold standard in the surgical treatment of periampullary tumors since its description by Allen Whipple in 1935. Over the past two decades, advances in minimally invasive surgical techniques have begun to be applied to pancreatic surgery as well. Robotic pancreaticoduodenectomy (RPD) was first described in 2003 and has since been increasingly performed worldwide. Potential advantages of robotic pancreaticoduodenectomy include reduced blood loss, shorter hospital stay, and faster postoperative recovery. However, prolonged operative times, high costs, and a steep learning curve stand out as disadvantages of the robotic approach. In this presentation, we aimed to evaluate the technical feasibility of RPD performed on a patient with a pancreatic head mass who presented to our clinic.

Material and Methods: Robotic pylorus-preserving pancreaticoduodenectomy was performed on a patient with a pancreatic head mass; the surgical technique and anastomosis stages are demonstrated step-by-step in this video.

Results: The operative time was 340 minutes, and blood loss was 150 mL; the patient was discharged without complications on postoperative day 6. and surgical margins were negative (R0).

Conclusion: Robotic pancreaticoduodenectomy is a technically feasible method that can be safely performed in selected cases without compromising oncological principles, offering the distinct advantages of minimally invasive surgery.

Keywords: Robotic, pancreas, whipple

[V-017]

Hepaticojejunostomy anastomosis technique in robotic pancreaticoduodenectomy

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Objective: Biliary reconstruction remains a technically demanding and complex step in minimally invasive hepatopancreatobiliary surgery. To date, no optimal hepaticojejunostomy (HJ) technique has been definitively established as superior in preventing biliary complications. In this presentation, we aim to describe our hepaticojejunostomy technique in robotic surgery, consisting of a continuous 4/0 V-Loc suture for the posterior wall and interrupted 4/0-5/0 PDS sutures for the anterior wall.

Material and Methods: Between April 2022 and February 2026, a total of 25 patients underwent fully robotic pancreatic surgery using the described hepaticojejunostomy technique at the Department of General Surgery, Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine. Patients were retrospectively analyzed in terms of treatment modalities, postoperative follow-up, and complications.

Results: The cohort consisted of 14 male and 11 female patients with a mean age of 62 years. Among them, 22 underwent pylorus-preserving pancreaticoduodenectomy, 1 underwent conventional pancreaticoduodenectomy, and 2 underwent total pancreaticoduodenectomy. The mean operative time was 430 minutes (range: 340-660), and the mean HJ anastomosis time was 28 minutes (range: 24-35). The average bile duct diameter was 7 mm. During a mean follow-up period of 15 months, no cases of biliary leakage or anastomotic stricture were observed.

Conclusion: The posterior continuous 4/0 V-Loc and anterior interrupted PDS hepaticojejunostomy technique used in robotic surgery appears to be a safe, effective, time-efficient, and cost-effective method, with complication rates comparable to those reported in the literature.

Keywords: Hepaticojejunostomy, pancreas, robotic surgery

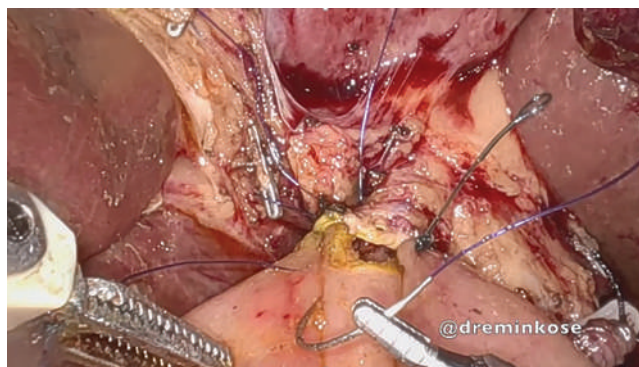


Figure 1. Posterior wall hepaticojejunostomy anastomosis.

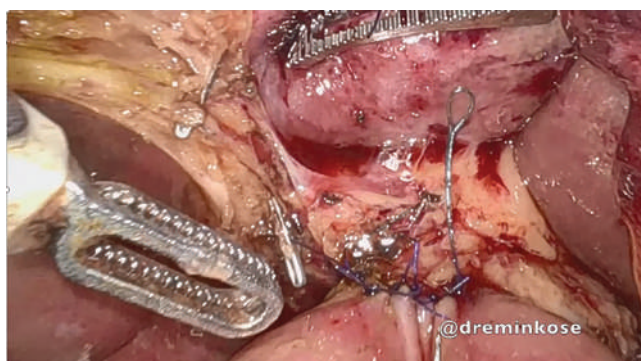


Figure 2. Anterior wall hepaticojejunostomy anastomosis.

Table 1. Descriptive characteristics of patients undergoing robotic hepaticojejunostomy

Parameters (mean/count)	Value
Age (mean)	62 (11-78)
Sex	
-Male	14
-Female	11
Bile duct diameter	
- <10 mm	15
- >10 mm	10
Pathology	
-Pancreatic head adenocarcinoma	8
-Ampulla of vater adenocarcinoma	4
- Neuroendocrine tumor	5
- IPMN	5
- Serous cystadenoma	2
- Acinar cystic neoplasia	1
Neoadjuvant therapy	0
Surgical technique	
-Pylorus-preserving	22
-Conventional	1
-Total pancreaticoduodenectomy	2

Table 2. Perioperative and postoperative outcomes of patients undergoing robotic hepaticojejunostomy

Outcome (mean or %)	Value
Operative time (min)	430 (340-660)
Hepaticojejunostomy anastomosis time (min)	28 (24-35)
Blood loss (mL)	180
Conversion to open surgery	8% (2/25)
Hospital stay (days)	9
POPF	20% (5/25)
Intensive care unit (ICU) stay (days)	1.67
Morbidity	16% (4/25)
Mortality	0
Biliary leakage	0
Biliary stricture	0

[V-018]

Robotic whipple procedureHüseyin Yılmaz, Sinan Şener, Fatih Türkoğlu, Ayşe Gül Aksoy

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Objective: A 72-year-old male patient presented with a two-month history of abdominal pain radiating to the back. Total abdominal ultrasonography (USG) revealed a distended gallbladder (diameter: 42 mm) with an increased wall thickness of 6.5 mm. Biliary sludge was observed within the lumen (cholecystitis). Both intrahepatic and extrahepatic bile ducts (diameter: 12.5 mm) were dilated. Further investigation was initiated after a 32 mm hypoechoic heterogeneous area was detected at the level of the pancreatic head. Laboratory results: AFP: 3.62 ng/mL, CA 19.9: 103 U/mL, CEA: 1.42 ng/mL, WBC: 4.72 K/uL, HGB: 11.5 g/dL, ALT: 197 U/L, AST: 136 U/L, LDH: 143 U/L, GGT: 777 U/L, ALP: 363 U/L, 373 U/L, lipase: 837 U/L, direct bilirubin: 4.61 mg/dL, total bilirubin: 4.68 mg/dL.

Material and Methods: Abdominal computed tomography (CT) demonstrated a dilated pancreatic duct, measuring 4.5 mm at the pancreatic head and 4 mm at the neck. Distal to this area, the common bile duct (CBD) showed blunt termination in the pancreatic head-periampullary region. At this level, a hypodense lesion measuring 20x13 mm in the coronal plane was identified. Upper abdominal MRI confirmed that there was no vascular invasion of the

portal vein, superior mesenteric artery (SMA), or superior mesenteric vein (SMV). Following the consensus of the multidisciplinary surgical oncology council, the patient underwent a robotic-assisted Whipple procedure via a five-port technique. Four main robotic ports were placed in the upper abdomen, maintaining an 8-10 cm distance between each other in a slightly convex or linear alignment. An assistant trocar was positioned at the extreme right lateral aspect to facilitate suctioning, clip application, and suture passage.

Results: During follow-up in the intensive care unit (ICU), a bilious drainage of 150 cc was recorded on postoperative day 1 (POD 1). On the same day, the patient was transferred to the general surgery ward. By POD 3, the drain output transitioned to a serous character. Oral intake (diet 1) was initiated on POD 4. As the patient tolerated the diet well, he was advanced to diet 2 on POD 5. During postoperative monitoring, a significant regression was observed in liver function tests (ALT, AST, ALP, GGT) and bilirubin levels. The image displays the en-bloc resection specimen from a robotic-assisted pancreatoduodenectomy (Whipple procedure). The specimen includes a distended gallbladder, the duodenum, and the pancreatic head. The surgical stapler is seen on the left for scale and orientation. The resection was performed with clear margins, targeting the hypodense mass previously identified in the pancreatic head/periampullary region.

Conclusion: The drain was removed on POD 6, and the patient was discharged in stable condition.

Keywords: Obstructive jaundice, pancreatic head cancer, robotic whipple procedure

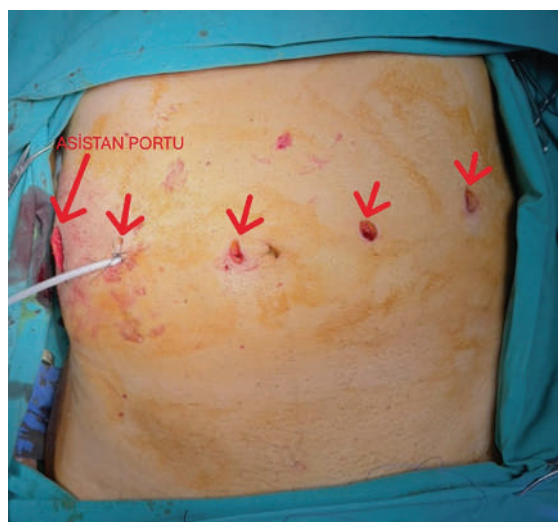


Figure 1. Five-port technique.



Figure 2. Specimen.

[V-020]**Our retroperitoneoscopic donor nephrectomy experience**

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Objective: Donor safety is the foremost priority in living-donor nephrectomy. Minimally invasive approaches are increasingly preferred to reduce donor morbidity, postoperative pain, and length of hospital stay. Retroperitoneoscopic donor nephrectomy (RPDN) is a valuable alternative because it minimizes intraperitoneal organ manipulation and may facilitate faster recovery. We present our single-surgeon experience with RPDN and early outcomes.

Material and Methods: We retrospectively reviewed 26 living-donor nephrectomies performed using a standardized retroperitoneoscopic technique by the same surgeon between November 2023 and May 2024. Demographics, operative time, number of renal arteries, peritoneal opening, postoperative pain scores (VAS), time to first flatus and bowel movement, discharge day, and complications were analyzed. Cases converted to open nephrectomy due to bleeding were excluded; additionally, three conversion cases were not included in the analysis.

Results: Mean donor age was 39.1 ± 10.7 years, and 69.2% were male. Mean operative time was 54.9 ± 13.5 minutes. Double renal arteries were present in 34.6% of donors. Peritoneal opening occurred in a small subset without additional morbidity. Mean length of stay/discharge time was 3.6 ± 0.9 days. Time to first flatus and first bowel movement was 9.5 ± 4.0 hours and 20.9 ± 5.4 hours, respectively. Early postoperative VAS scores were low and did not increase during follow-up. One donor developed a lymphocele; no major complication requiring additional surgery was observed.

Conclusion: Living-donor nephrectomy is among the most ethically sensitive procedures in modern surgery, directly reflecting the principle of primum non-nocere ("first, do no harm"), as a healthy organ is removed from a healthy volunteer. Therefore, donor safety and preservation of postoperative comfort and quality of life are paramount. Compared with transabdominal donor nephrectomy, which may carry bowel-related risks due to colon mobilization, RPDN avoids intraperitoneal entry and targets a retroperitoneal organ through its natural anatomical planes. Although RPDN is technically demanding—owing to the limited working space, the different/reversed anatomical perspective, and close trocar positioning—our early outcomes demonstrate that it can be performed safely with favorable recovery parameters in appropriately selected donors. While commonly adopted by urologists, we believe RPDN should also be within the armamentarium of experienced general surgeons.

Keywords: Kidney transplantation, donor safety, retroperitoneoscopic donor nephrectomy



Figure 1. Trocar entries: Trocar placement in RPDN. Ureter and retroperitoneum dissection.

RPDN: Retroperitoneoscopic donor nephrectomy.

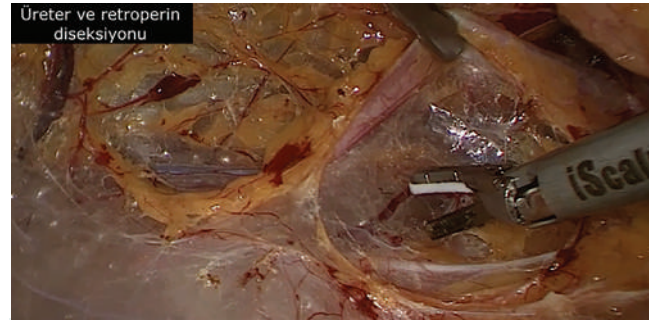


Figure 2. Dissection of the ureter in the retroperitoneum after trocar entry. Dissection of the left lumbar vein.

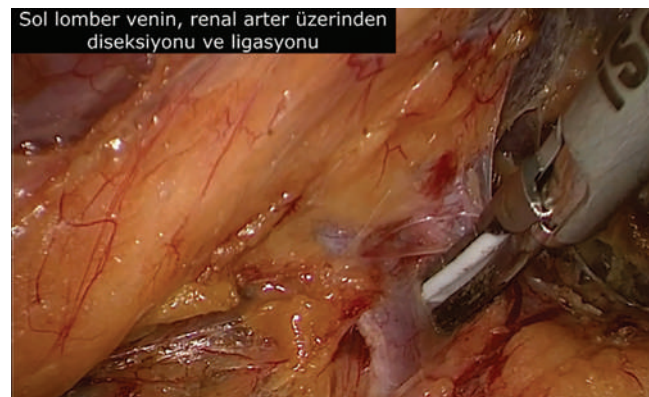


Figure 3. One of the key points in kidney donor surgery. The left lumbar vein passes over the left renal artery and flows into the left renal vein. It is difficult to reach the renal artery without dissecting the lumbar vein. Possible bleeding during dissection can sometimes be serious.

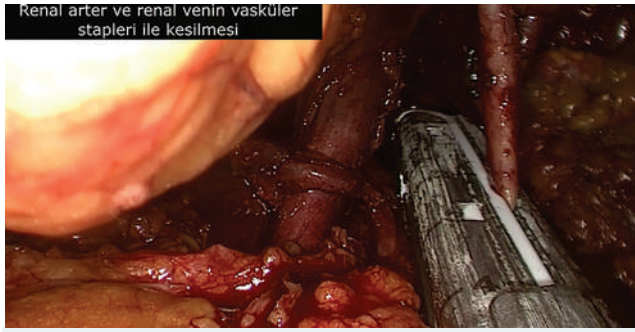


Figure 4. Cutting the renal artery with a vascular stapler.



Figure 5. Appearance of the lodge after nephrectomy.

[V-021]

Kidney transplantation performed using an ectopic pelvic kidney in laparoscopic donor nephrectomy

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Objective: Living donor kidney transplantation is the most effective treatment method for patients with end-stage renal failure. Compared to conventionally located kidneys, ectopic pelvic kidneys are traditionally considered a relative contraindication for living donor transplantation due to variable vascular anatomy, short ureter, and surgical difficulties. This case report aims to present an ectopic pelvic kidney that was removed laparoscopically.

Material and Methods: A 26-year-old female patient diagnosed with chronic renal failure was scheduled for a living-donor kidney transplant. Preoperative examination of the 45-year-old mother, considered as a potential donor, revealed an ectopic kidney located at the pelvic inlet level, to the left of the midline. The donor's serum creatinine level was 0.58 mg/dL, and eGFR was 117.32 mL/min/1.73 m². A 24-hour urine test showed a creatinine clearance of 134.04 mL/min. Computed tomography angiography revealed the ectopic kidney to have a single renal artery, a single renal vein, and a single ureter. 99mTc-DMSA scintigraphy showed the ectopic kidney's contribution to total renal function to be 40%. Due to the lack of an alternative donor and the donor's high functional reserve, the use of the ectopic kidney was planned. Laparoscopic donor nephrectomy was performed through four ports and an 8-cm infraumbilical midline incision. The graft was anastomosed end-to-side to the external iliac artery and vein.

Results: The operation was completed without complications, and the warm ischemia time was recorded as two minutes. The donor was monitored without complications in the postoperative period, and on the 3rd postoperative day, the creatinine level was 0.73 mg/dL, and the patient was discharged. Graft function started early in the recipient. The serum creatinine level, which was 6.34 mg/dL preoperatively, decreased to 1.24 mg/dL on the 7th postoperative day. At four months of follow-up, the recipient's creatinine level was observed to be 1.09 mg/dL. No major or minor surgical complications occurred in either the donor or the recipient.

Conclusion: Ectopic pelvic kidneys can be safely used in living donor kidney transplantation in selected cases in experienced centers and with appropriate preoperative evaluation. A minimally invasive surgical approach is advantageous in such cases. This case demonstrates that ectopic pelvic kidneys may be suitable candidates to expand the living donor pool.

Keywords: Ectopic pelvic kidney, laparoscopic donor nephrectomy, living donor kidney transplantation, minimally invasive surgery

[V-022]**Intraoperative crisis in sleeve gastrectomy: Intracorporeal repair of an opened staple line**

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Objective: Sleeve gastrectomy is a widely performed and effective bariatric procedure for the treatment of morbid obesity. The most common early complications are staple-line bleeding and leak. Tissue thickness, compression time, and technical factors during stapler firing directly influence staple-line integrity. Although uncommon, difficult stapler firing may result in significant intraoperative staple-line problems requiring advanced laparoscopic management. In this video presentation, we aim to demonstrate the operative management of a case complicated by severe bleeding after difficult stapler firing and subsequent staple-line disruption during reinforcement suturing.

Material and Methods: A patient with morbid obesity underwent laparoscopic sleeve gastrectomy using standard port placement and complete greater curvature mobilization. Gastric transection was initiated over a calibration bougie. During the third stapler firing, marked resistance was encountered in the cutting phase. After opening the device, significant staple-line bleeding was observed. Hemostasis was achieved with compression and targeted hemostatic measures. Gastric transection was then completed. A methylene blue leak test showed no extravasation. The suspicious segment appeared macroscopically comparable to the remaining staple line. Staple-line reinforcement was initiated proximally using continuous imbrication sutures combined with omentopexy. Upon reaching the problematic segment, staple-line separation occurred during suture passage. The defect was repaired intracorporeally with primary suturing and further reinforced. A repeat leak test was performed after repair.

Results: The repeat leak test demonstrated no leakage and complete hemostasis was confirmed. The postoperative course was uneventful, with no evidence of bleeding, leak, or stenosis. Oral intake progressed according to protocol, and the patient was discharged without complications. This case illustrates that difficult stapler firing may compromise staple-line strength even when gross appearance is normal, and that disruption can occur during reinforcement suturing.

Conclusion: Difficult stapler firing during sleeve gastrectomy may lead to occult staple-line weakness and unexpected disruption despite normal macroscopic appearance. In segments with challenging firing, surgeons should consider a low threshold for reinforcement, meticulous suturing technique, and repeat leak testing. Advanced intracorporeal repair skills and systematic intraoperative assessment are critical for safe management of such complications and can lead to favorable patient outcomes.

Keywords: Staple line, dehiscens, bleeding, sleeve gastrectomy

[V-023]**An economic alternative to barbed sutures: The modified “loop-and-clip” PDS method**

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Objective: Barbed sutures (e.g., V-Loc-type) reduce the need for intracorporeal knot tying and may shorten laparoscopic suturing time; however, they are not always readily available. In this study, we aimed to assess the feasibility of a practical V-Loc-inspired modification using 2/0 PDS based on a “posterior loop” concept to facilitate knotless suturing.

Material and Methods: In cases requiring laparoscopic intracorporeal suturing, a 2/0 PDS suture was prepared by cutting it to a 15 cm length and creating a loop knot at the posterior end. At the start of suturing, the needle was passed through this loop after the first tissue bite, eliminating the need for an initial intracorporeal knot. Since a barbed/fishbone-like structure could not be reproduced, there was no active anti-backsliding mechanism; therefore, tension and tissue approximation were visually monitored throughout the suture line. Finally, the suture was tensioned and terminated by applying a metallic clip at the base of the suture.

Results: The posterior loop modification eliminated the need for intracorporeal knot tying throughout the procedure. This simplified suturing, particularly in confined working spaces, and resulted in a marked reduction in suturing/operative time. Tissue approximation appeared satisfactory; however, due to the absence of barbs, line stability depended on the operator's tension control and clip-based termination.

Conclusion: A posterior loop modification of a 2/0 PDS suture appears to be a feasible and practical knotless alternative for laparoscopic intracorporeal suturing, with the potential to significantly reduce operative time by avoiding knot tying. Nevertheless, because it lacks an intrinsic anti-backsliding mechanism, security relies on proper tension management and clip termination. Larger comparative studies with standardized outcomes and follow-up are needed to better define efficacy and safety versus commercially available barbed sutures.

Keywords: PDS loop suture, laparoscopic sleeve gastrectomy, staple line reinforcement, laparoscopic suturing

[V-024]

Bariatric surgery in obese patients with a history of nissen fundoplication: Video presentation of different approachesCihan Sahan¹, Hilmi Yazıcı²¹Aktif International Hospital, Istanbul²Marmara University, Pendik Training and Research Hospital, Istanbul

Objective: Bariatric surgery in obese patients with a history of Nissen fundoplication presents technical challenges due to altered upper gastrointestinal anatomy, adhesions, and the need for adequate reflux control. Evidence regarding the optimal surgical strategy in this patient population remains limited. This video presentation aims to demonstrate two different surgical approaches applied in such cases.

Material and Methods: Two obese patients with a previous history of Nissen fundoplication who were indicated for bariatric surgery were retrospectively evaluated. All procedures were performed laparoscopically. In the first case, a disrupted fundoplication associated with a hiatal hernia was identified. In the second case, the Nissen wrap was intact and gastroesophageal reflux symptoms were well controlled. Surgical procedures were analyzed using video recordings.

Results: In the first case, detachment of the existing fundoplication and a significant hiatal hernia were observed. Roux-en-Y gastric bypass was successfully performed concomitantly with hiatal hernia repair. In the second case, sleeve gastrectomy was carried out while preserving the fundoplication. No intraoperative complications were observed in either patient. No major complications occurred in the early postoperative period, and reflux symptoms were well controlled.

Conclusion: In obese patients with prior Nissen fundoplication, the choice of bariatric procedure should be individualized based on the integrity of the fundoplication and clinical symptoms. With appropriate patient selection and meticulous surgical technique, both Roux-en-Y gastric bypass and sleeve gastrectomy with wrap preservation can be safely performed. This video presentation aims to provide practical guidance for surgical decision-making in this complex patient group.

Keywords: Nissen fundoplication, bariatric surgery, obesity, Roux-en-Y gastric bypass, sleeve gastrectomy

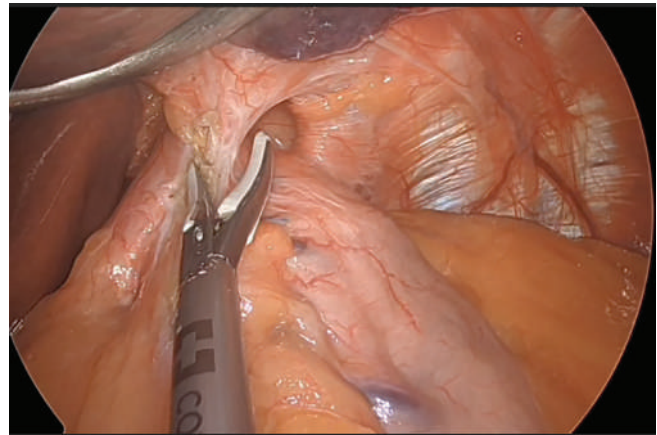


Figure 1. Hiatal hernia.

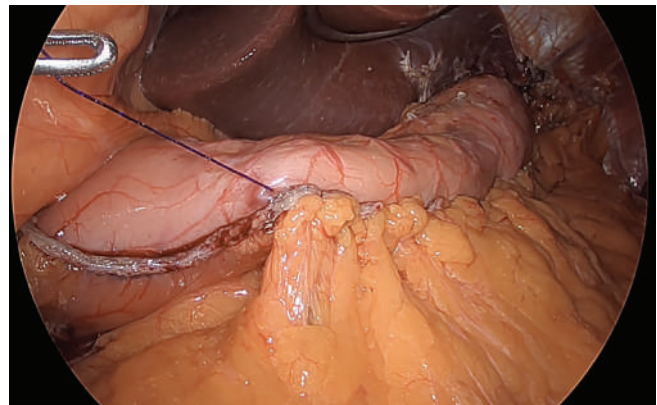


Figure 2. Staple line omentopexy in sleeve gastrectomy.

Table 1. Bariatric surgery outcomes in two obese patients with previous nissen fundoplication

Characteristics	Patient 1	Patient 2
Age/sex	50/female	45/female
Previous surgery	Nissen fundoplication	Nissen fundoplication
Bariatric procedure performed	Roux-en-Y gastric bypass + hiatal hernia repair	Sleeve gastrectomy (Nissen preserved)
Preoperative BMI (kg/m ²)	40	42
Postoperative 6-month BMI (kg/m ²)	29	28
Total weight loss (6 months)	27 kg	35 kg
Preoperative GERD-HRQL score	32 (severe symptoms)	5 (no/minimal symptoms)
Postoperative GERD-HRQL score (6 months)	5 (no/minimal symptoms)	4 (no/minimal symptoms)
Reflux symptoms	Marked improvement after surgery	No change
Comorbidities	None	None
Chronic medications	None	None

GERD-HRQL: Gastroesophageal reflux disease-health-related quality of life, BMI: Body mass index.

[V-026]**Laparoscopic retrocolic jejunal transposition technique in HPB and upper gastrointestinal surgery**

Ulvi Majidli, [Habip Sarı](#), Mert Çöl, Necip Tolga Baran, Ahmet Seki, Koray Koşmaz, Ümit Özdemir, Abdullah Şenlikçi, Mustafa Taner Bostancı

University of Health Sciences Türkiye, Ankara Etlik City Hospital, Ankara

Objective: The reconstructive phase in hepatopancreatobiliary (HPB) and upper gastrointestinal (UGI) surgery represents a technically demanding step, particularly in minimally invasive procedures. Safe transposition of the jejunal limb with preserved vascularity and without tension is crucial for anastomotic success. This video presentation aims to demonstrate the standardized steps of the laparoscopic retrocolic transposition technique applicable to various HPB and UGI reconstructions.

Material and Methods: The technique is utilized in gastroenterostomy, esophagojejunostomy, pancreaticojejunostomy, and hepaticojejunostomy. The gastrocolic ligament is divided to enter the lesser sac, and the ligament of Treitz is identified. A controlled window is created through an avascular area of the transverse mesocolon, allowing retrocolic transposition of the jejunal limb to the target field. Particular attention is paid to mesenteric orientation, prevention of torsion, vascular integrity, and ensuring a tension-free anastomosis. In cases of gastroenterostomy, a Braun enteroenterostomy is performed between the afferent and efferent limbs to reduce bile reflux and the risk of afferent loop syndrome. The video highlights key anatomical landmarks, technical nuances, and critical safety steps for secure transposition.

Results: The retrocolic approach provides a shorter and more direct jejunal route, facilitating a tension-free and well-perfused anastomosis. Proper mesocolic window creation and meticulous orientation help prevent mesenteric torsion and vascular compromise. The addition of Braun anastomosis may improve postoperative functional outcomes in gastroenterostomy cases.

Conclusion: The laparoscopic retrocolic transposition technique is a safe, reproducible, and teachable method applicable to multiple reconstructive procedures in HPB and UGI surgery. Standardization of this approach may enhance anastomotic quality and contribute to improved surgical outcomes in minimally invasive surgery.

Keywords: Laparoscopic surgery, retrocolic transposition, jejunal reconstruction

[V-028]**Laparoscopic endoscopic cooperative surgery (LECS) for gastric gastrointestinal stromal tumors: A case report**

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İzmir Katip Çelebi University, Atatürk Training and Research Hospital, İzmir

Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal neoplasms of the gastrointestinal tract. GISTs are staged according to tumor size, mitotic index, lymph node involvement, and the presence of distant metastases. Surgical resection is the standard treatment for localized GISTs. Various surgical techniques have been described in the literature. Since its introduction in 2008, laparoscopic endoscopic cooperative surgery (LECS) has been proposed as a safe and effective alternative surgical approach.

Material and Methods: A 71-year-old female patient was asymptomatic and was found to have a gastric mass during routine screening endoscopy. Subsequent endoscopic ultrasonography (EUS) revealed a lesion measuring 40-45 mm in diameter, located on the lesser curvature of the mid-gastric corpus. The lesion showed a central depression with ulceration, while the surrounding mucosa appeared normal. EUS demonstrated a hypoechoic, heterogeneous mass originating from the muscularis propria layer with predominant endoluminal growth, measuring up to 40-mm in its greatest dimension. Contrast-enhanced abdominal computed tomography revealed no evidence of local invasion or distant metastasis. The patient underwent laparoscopic endoscopic cooperative surgery (LECS). Histopathological examination revealed a tumor measuring 4.2×4.1×2.8 cm, classified as histological grade G1, with a mitotic count of 1 per 50 high-power fields. No necrosis or cytological atypia was identified, and the surgical margins were negative. According to the Miettinen-Lasota risk classification, the risk of progressive disease was very low.

Results: GISTs are the most frequently encountered mesenchymal tumors of the gastrointestinal system and are most commonly located in the stomach. The majority of patients are asymptomatic, and tumors are often detected incidentally. Surgical resection remains the standard treatment for localized gastric GISTs, and routine lymph node dissection is not recommended. Various surgical techniques have been described to achieve these objectives. Since 2008, LECS has gained increasing acceptance due to its ability to achieve oncologically safe margins while minimizing gastric resection and reducing postoperative complications. Although full-thickness gastric wall opening during LECS raises concerns regarding potential tumor seeding, sufficient evidence demonstrating increased oncological risk has not been reported in the literature.

Conclusion: LECS is a safe and effective surgical technique for the treatment of gastric GISTs. It allows preservation of gastric function, ensures oncologically safe resection margins, and is associated with reduced postoperative complication rates. LECS should be considered a valuable minimally invasive option in appropriately selected patients with gastric GISTs.

Keywords: Gastrointestinal stromal tumor, laparoscopic endoscopic cooperative surgery

[V-029]**Video presentation of a case undergoing laparoscopic sigmoid colon resection due to recurrent diverticulitis**Fahri Yetişir¹, Mete Yarkin Yetişir²¹Clinic of General Surgery, Acıbadem Bayındır Private Hospital, Ankara²Medical School Student, Başkent University Faculty of Medicine, Ankara

Objective: Diverticulitis has become more common in recent years, particularly in Western societies, in parallel with changes in diet and lifestyle. It is a gastrointestinal disease frequently seen especially in the elderly population. While patients with diverticula may remain asymptomatic for long periods, diverticulitis attacks of varying severity can occur and may lead to intra-abdominal abscess, peritonitis, sepsis, and fistula formation. In patients experiencing recurrent attacks and those who develop complications, surgical treatment may become unavoidable. In this video, the laparoscopic sigmoid colon resection performed in a male patient with diabetes and hypertension is presented in all stages.

Material and Methods: Our patient had been hospitalized four times within the last year due to recurrent diverticulitis attacks and received medical treatment. Abdominal computed tomography revealed a contained perforation related to a diverticulitis attack in the sigmoid colon and thickening of the colonic wall. Colonoscopy showed widespread diverticula in the sigmoid colon. An elective surgery was recommended by the gastroenterology and general surgery board.

Results: After completing a full systemic evaluation, laparoscopic sigmoid colon resection was planned. The patient underwent laparoscopic sigmoid colon resection and an end-to-side colorectal anastomosis. No intraoperative complications occurred. In the postoperative period, the patient was mobilized early, oral intake was initiated without problems, and he was discharged in good condition on postoperative day 4.

Conclusion: No complications were observed during follow-up visits on day 10, and at 1 and 6 months. Laparoscopic sigmoid colon resection is a minimally invasive, safe, and effective treatment option for patients who require surgery due to recurrent diverticulitis attacks. This case highlights the advantages of laparoscopic surgery and demonstrates the importance of the surgical approach in the treatment of diverticulitis.

Keywords: Recurrent diverticulitis, laparoscopic sigmoid colectomy, colorectal anastomosis

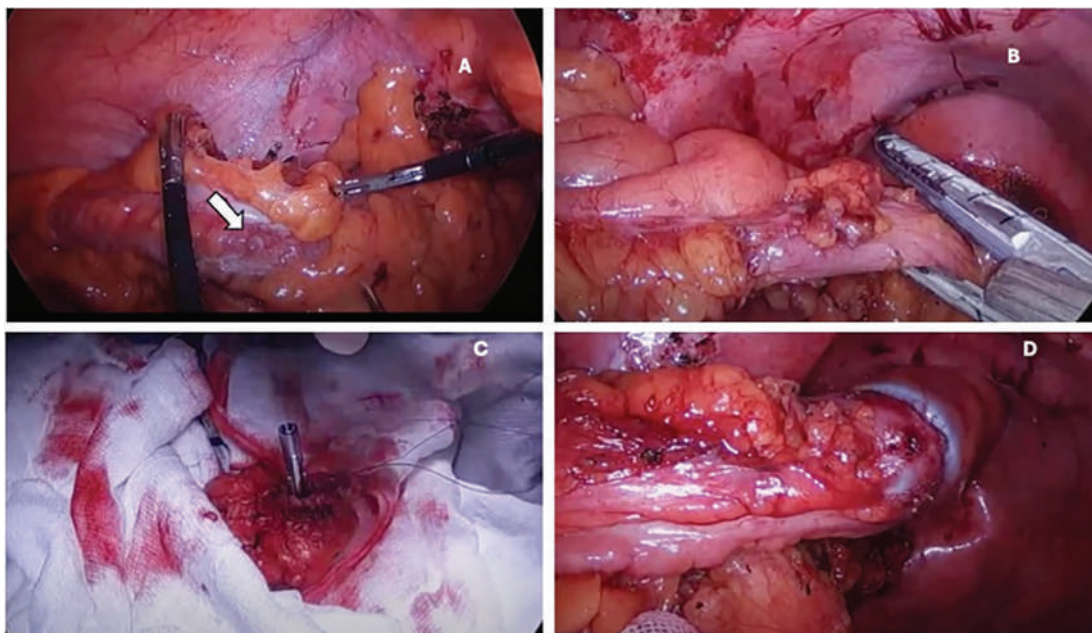


Figure 1. A) Exposure of the sigmoid colon with numerous diverticula of varying sizes (the arrow indicates a diverticulum). B) Resection of the diverticular sigmoid colon proximally and distally using a tri-stapler. C) Placement of a 31-mm intraluminal circular stapler anvil into the proximal colon end. D) Construction of an end-to-side colorectal anastomosis.

[V-030]**Altemeier procedure in complete rectal prolapse: Video technical presentation**

Betül Kübra Aydın Mucuk, Ramazan Kozan, Hannan Özgenç Elieyioğlu, Mustafa Anıl Dağ

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Objective: Surgical methods for treating external rectal prolapse are divided into two main categories: perineal and abdominal approaches. Perineal methods are generally preferred in elderly individuals with comorbidities due to their higher recurrence rates. Abdominal methods, while having lower recurrence rates, carry higher risks of comorbidity, impotence, and infertility. The integration of levatoroplasty into perineal approaches provides superior functional outcomes. The combination of these factors brings about a re-evaluation of perineal surgical techniques, which are rarely seen in clinical practice. This video presentation demonstrates the technical steps of the Altemeier Procedure combined with posterior levatoroplasty and examines perineal approaches in detail through a case study.

Material and Methods: A 67-year-old female patient presented to our clinic with prolapse-related symptoms persisting for five years. She reported spontaneous prolapse upon standing, incontinence, and difficulty with defecation. Her medical history included chronic conditions such as hypertension, diabetes, hyperlipidemia, and hypothyroidism. She had previously undergone suture rectopexy operations at various centers in 2021, 2022, and 2023. The patient was operated on under spinal anesthesia in the lithotomy position. A circumferential incision, involving all layers of the rectum, was made 1 cm proximal to the dentate line. The redundant rectum was mobilized extraperitoneally. The rectovaginal septum was preserved, the peritoneal pouch was opened, and the pouch of Douglas was accessed. After mobilizing the prolapsed rectum and sigmoid colon, mesocolon dissection was performed. Posterior levatoroplasty was applied to prevent mesorectum prolapse and enhance continence. Following perineal rectosigmoidectomy, a colo-anal anastomosis was performed using full-thickness, interrupted suture technique.

Results: Proctologic examination revealed approximately 10 cm of complete rectal prolapse. No additional pathological findings were observed during colonoscopic examination. The patient's preoperative Wexner continence score (WCS) was determined to be 18. Postoperatively, WCS was recorded as 8 at week 1 and 5 at month 1. The patient had no analgesic requirement in the postoperative period.

Conclusion: The Altemeier procedure for rectal prolapse treatment has proven to be an effective and reliable option, not requiring postoperative pain management. Combining this procedure with levatoroplasty significantly contributes to improving functional outcomes.

Keywords: Altemeier procedure, rectal prolapse

[V-031]**Delorme prodecure combined with levatoroplasty in the surgical treatment of complete rectal prolapse**

Betül Kübra Aydın Mucuk, Ramazan Kozan, Mete Varoğlu, Mustafa Anıl Dağ

Gazi University Faculty of Medicine, Ankara

Objective: Rectal prolapse is a benign condition typically affecting elderly patients. Constipation is associated with prolapse in 15-65% of cases. Common symptoms include tenesmus, a sensation of tissue protruding from the anus (reducible or not), and incomplete bowel evacuation. Surgical intervention is the primary treatment for rectal prolapse, utilizing two main approaches: Abdominal and perineal. When perineal procedures are combined with levatoroplasty, this therapeutic strategy offers low recurrence, minimal morbidity, and virtually zero mortality.

Material and Methods: A 72-year-old female patient presented with prolapse-related symptoms for 12 years. She described spontaneous prolapse upon standing, wetness, and difficulty with fecal continence. Her medical history was unremarkable for chronic diseases. Seven years prior, she underwent suture rectopexy at a different center. The patient was operated on under spinal anesthesia in the lithotomy position. A circumferential incision was made 1 cm proximal to the dentate line, involving all layers of the rectum. This incision was carefully advanced to separate the rectal mucosa and submucosa from the muscular layer. The mucosal flap was bluntly and sharply dissected proximally from the rectal muscle layer up to the superior border of the prolapse. During this stage, care was taken to preserve the integrity of the mucosa. The prolapsed rectal muscle layer was thickened by longitudinal plication, thereby narrowing the rectal lumen. This plication was performed using absorbable sutures. The excess mucosal flap overlying the plicated muscle layer was carefully resected. The remaining mucosal edges were joined at a level close to the dentate line using full-thickness, interrupted absorbable sutures in a colo-anal anastomosis fashion. Posterior levatoroplasty was performed to enhance continence and augment posterior rectal support.

Results: Preoperative Wexner score was 15 for the patient, with no additional pathological findings on colonoscopic examination. Postoperatively, on day 10, the score was measured as 6.

Conclusion: Perineal approaches can be primarily considered for elderly rectal prolapse patients with comorbidities.

Keywords: Delorme procedure, rectal prolapse

[V-032]**Variant SMA anatomy: Surgical relevance in right hemicolectomy**

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Objective: The superior mesenteric artery (SMA) arises from the aorta just below the celiac trunk at the level of the first lumbar vertebra. It supplies midgut derivatives from the distal duodenum to the mid-transverse colon. During its course, the SMA lies adjacent to the superior mesenteric vein (SMV) and, in normal vascular anatomy, is positioned left of the SMV. This relationship is critically important in pancreatic and colonic surgery. Complete mesocolic excision (CME) is currently regarded as the gold standard radical technique in colon cancer surgery. The procedure involves central ligation of vascular structures without violating visceral fascia, thereby ensuring maximal lymph node dissection. CME has demonstrated benefits in reducing local recurrence and improving survival. Successful application of this technique requires precise knowledge of the SMA and its branches, which may present with anatomical variations. In this context, we report a rare SMA variation encountered during surgery.

Material and Methods: A 56-year-old female patient was referred to our department following colonoscopy that revealed an ulcerovegetative mass in the ascending colon. She presented with fatigue, severe anemia, and blood in stool. Biopsy confirmed moderately differentiated adenocarcinoma. Contrast-enhanced thoracoabdominopelvic CT demonstrated a cT2N1M0 lesion on the medial wall of the ascending colon. A laparoscopic right hemicolectomy using the CME technique was planned.

Results: During surgery, dissection toward the ileocolic pedicle origin revealed that the ileocolic artery entered the mesentery with a short trunk, arising from a vascular structure extending longitudinally to the right of the SMV. As dissection advanced medially over the SMV, this vessel was identified as the SMA, running along the right lateral aspect of the SMV. The mesentery was freed along the SMV from the pancreas. Proximally, the right colic artery was observed to arise directly from the SMA with a short trunk. The ileocolic artery, right colic artery, and right branch of the middle colic artery were ligated, and central vascular ligation was completed while preserving the SMA.

Conclusion: In CME surgery for ascending colon tumors, awareness of SMA and branch variations is essential to avoid catastrophic vascular injuries. The variation described, in which the SMA runs along the right side of the SMV, has been reported mainly in association with intestinal rotation anomalies but is rarely seen in isolation. In such cases, the distal SMA may be mistaken for the ileocolic artery and inadvertently ligated. Strict adherence to CME principles, particularly completing dissection to the left border of the SMV, clarifies the anatomy and may prevent serious complications.

Keywords: Superior mesenteric artery, right hemicolectomy, anatomy

[V-033]**Colonic pouch reconstruction in robotic ultra-low anterior resection**

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Objective: To demonstrate the technique of colonic pouch reconstruction in a female patient undergoing robotic ultra-low anterior resection for rectal cancer and to discuss its potential functional benefits.

Material and Methods: A female patient diagnosed with low rectal adenocarcinoma underwent robotic ultra-low anterior resection with total mesorectal excision. Following resection, a colonic pouch was constructed and colorectal anastomosis was performed using a circular stapler. The video presentation illustrates key technical steps, pouch formation, and intraoperative tips.

Results: The procedure was completed successfully without intraoperative complications. Colonic pouch reconstruction increased neorectal reservoir capacity after low colorectal anastomosis. No early postoperative anastomotic leakage or major complications were observed. The colonic pouch was considered beneficial in reducing the risk of low anterior resection syndrome.

Conclusion: Colonic pouch reconstruction during robotic ultra-low anterior resection is a safe and feasible technique. It may improve postoperative functional outcomes, particularly in patients undergoing very low colorectal anastomosis. This video aims to contribute to the standardization of colonic pouch formation in minimally invasive rectal cancer surgery.

Keywords: Colonic pouch, rectal cancer, surgical technique

[V-034]**Tailgut cyst excision: A rare case**

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Objective: Retrorectal tumors are rare entities, and a significant proportion of these lesions consist of congenital tailgut cysts. These lesions are usually asymptomatic; however, they may cause clinical symptoms due to pelvic compression. They are approximately three times more common in women than in men. In this presentation, we report the surgical management and outcome of a patient with a retrorectal tailgut cyst.

Material and Methods: The patient was placed in the jack-knife position under general anesthesia. After bladder catheterization and rectal irrigation, sterile preparation of the surgical field was performed. Following preoperative planning, a concave incision was made to initiate the procedure. After dissecting through the skin and subcutaneous tissue, the coccyx was excised to provide adequate exposure. Dissection was continued until the cyst located on the left side of the rectum was identified. During this step, intraoperative rupture of the cyst was observed. Although rupture is undesirable, complete en bloc excision remains the primary surgical objective in tailgut cysts. Intermittent bimanual examination was performed throughout the procedure to prevent rectal injury. After en bloc excision, an air-water test was conducted to confirm rectal integrity. Following hemostasis, the operative field was irrigated with normal saline. Two Jackson-Pratt drains were placed in the surgical bed. The subcutaneous tissues were closed using absorbable polyglactin multifilament sutures, and the procedure was completed.

Results: The lesion was successfully excised en bloc. Rectal integrity was preserved, and no leakage was detected during the air-water test. No early postoperative complications were observed. The patient was discharged uneventfully after appropriate drain management. Histopathological examination confirmed the diagnosis of a tailgut cyst, with no evidence of malignancy.

Conclusion: Tailgut cysts are rare congenital lesions located in the retrorectal space and are usually asymptomatic. However, they may present with symptoms such as constipation, urinary retention, and incomplete evacuation. Various surgical approaches have been described, including transabdominal, transsacral, intersphincteric, transsphincteric, parasacrococcygeal, and transanal techniques. Regardless of the chosen method, complete en bloc excision remains the gold standard for preventing recurrence. Studies from the Mayo Clinic emphasize that complete resection is essential for long-term success. Surgery should be performed by experienced surgeons to minimize morbidity. Preoperative biopsy is generally discouraged due to the risk of infection and tumor seeding. Although most tailgut cysts are benign, malignant transformation occurs in approximately 2-13% of cases, most commonly adenocarcinoma. In conclusion, appropriate surgical planning and complete excision are fundamental for achieving optimal outcomes in patients with retrorectal tailgut cysts.

Keywords: Retrorectal mass, tailgut cyst, complete excision

[V-035]**Robotic portal vein wedge resection during whipple procedure for pancreatic cancer**

Halit Topal

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Objective: Vascular involvement of the portal vein is frequently encountered in patients with pancreatic head adenocarcinoma undergoing pancreatoduodenectomy (Whipple procedure). In selected cases with limited venous wall infiltration, tangential portal vein wedge resection with primary closure allows oncologically adequate resection while avoiding segmental venous reconstruction. Robotic surgery provides enhanced dexterity, three-dimensional visualization, and improved suturing precision, facilitating safe vascular techniques.

Material and Methods: This surgical video demonstrates a fully robotic pancreatoduodenectomy with portal vein wedge resection and primary venous repair. After standard Kocher maneuver and uncinate dissection, limited tumor adherence to the portal vein is identified. Vascular control is achieved using atraumatic bulldog clamps by tangential clamping of the portal vein. A wedge resection of the infiltrated venous wall is performed. The venous defect is subsequently closed primarily using fine non-absorbable monofilament sutures under robotic magnified vision. The clamp was released allowing for inspection for bleeding or stenosis, confirming adequate portal flow.

Results: The robotic platform enables precise vascular dissection and suturing, minimizing manipulation of the portal vein. Tangential clamping maintains partial portal flow and reduces bowel congestion and hepatic ischemia time. Primary closure avoids prosthetic or autologous graft reconstruction and may shorten operative time while maintaining oncologic radicality.

Conclusion: Robotic portal vein wedge resection with primary closure during pancreatoduodenectomy is a safe and feasible technique in carefully selected pancreatic cancer patients with limited venous involvement. The approach combines oncologic adequacy with technical efficiency and represents a valuable addition to advanced minimally invasive pancreatic surgery.

Keywords: Pancreatic cancer, portal vein resection, robotic

[V-036]**Pushing the boundaries of robotic surgery: Experience from four cases**

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Objective: Robotic surgery has evolved from a novel minimally invasive tool into a versatile surgical platform capable of addressing complex anatomical, revisional, and inflammatory conditions. Advances in three-dimensional visualization, wristed instrumentation, and ergonomic precision have broadened the scope of procedures that can be performed safely and effectively using a minimally invasive approach.

Material and Methods: This video presentation demonstrates four distinct robotic procedures performed in different surgical domains: left lateral liver segmentectomy and oesophagectomy, robotic release for median arcuate ligament syndrome (MALS), robotic distalization of a Roux-en-Y gastric bypass as a revisional bariatric procedure, and robotic repair of a colovesical fistula. Each case was selected to illustrate a unique challenge—vascular-adjacent dissection, revisional metabolic surgery, and complex pelvic inflammatory disease—and to highlight the technical advantages offered by robotic assistance.

Results: In the MALS case, robotic magnification and precise dissection enabled safe decompression of the celiac axis while minimizing vascular and neural injury. Robotic gastric bypass distalization allowed controlled adhesiolysis, accurate bowel measurement, and secure reconstruction in a high-risk revisional setting. In the colovesical fistula repair, enhanced visualization within the narrow pelvis facilitated meticulous fistula takedown and reconstruction while preserving surrounding organs. Across all cases, robotic surgery enabled effective management of complexity that would traditionally require open surgery or carry increased morbidity.

Conclusion: These cases collectively demonstrate that robotic surgery has expanded the borders of modern surgery by enabling minimally invasive solutions for procedures involving critical vascular structures, altered anatomy, and hostile operative fields. Robotic platforms are not limited to specific procedures but serve as a concept-driven extension of surgical capability, enhancing precision, safety, and reproducibility across diverse and challenging clinical scenarios.

Keywords: Robotic surgery, minimally invasive, complex cases

[V-037]**Robotic splenectomy for complex splenic artery aneurysms using a clip by clip technique**

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Objective: Splenic artery aneurysms (SAAs) are the most common type of visceral arterial aneurysms and require intervention when symptomatic, larger than 2-cm, or diagnosed in women of childbearing age due to their high-risk of rupture. Although endovascular repair is generally preferred, it may be unfeasible in cases of severe arterial tortuosity or hilar involvement, where catheter navigation and reliable aneurysm exclusion are limited. Open surgery remains a traditional alternative but carries increased morbidity, especially in young and otherwise healthy patients.

Material and Methods: We report a case of a patient with two complex SAAs, one located near the celiac origin and the other deeply at the splenic hilum. Owing to severe arterial tortuosity and limited endovascular access, robotic splenectomy was performed. A sequential clip-by-clip technique was used to achieve vascular control, starting from the mid-segment of the splenic artery and progressing proximally toward the aneurysmal origin. The procedure was completed using robotic instrumentation without conversion.

Results: The clip-by-clip approach enabled secure vascular control and safe excision of both aneurysms. No intraoperative complications occurred. The patient had an uneventful postoperative course and was discharged on postoperative day four.

Conclusion: Robotic splenectomy using a clip-by-clip technique represents a feasible and effective alternative for the management of anatomically complex SAAs when endovascular and open approaches are limited. The enhanced precision and articulation of robotic systems facilitate safe dissection and vascular control in confined operative fields. This case highlights the technical feasibility and potential clinical benefits of robotic management in challenging aneurysm locations.

Keywords: Robotic surgery, splenic artery aneurysm, robotic splenectomy

[V-038]**Surgery in the hands of the robot: Safe resection and lymph node dissection in gastric cancer**Alparslan Ertenlice¹, Tolga Dinç²

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Objective: Throughout history, gastric cancer has been one of the major health problems affecting humanity. The earliest information regarding this disease can be found in papyri dating back to ancient Egypt. Today, gastric cancer remains an important global health issue and is currently the fifth most common cancer worldwide. It continues to represent a significant global health burden as one of the leading causes of cancer-related mortality worldwide.

Material and Methods: Although the epidemiological characteristics and surgical treatment approaches for gastric cancer vary across different geographical regions, resection of the primary tumor and the associated lymph nodes remains the cornerstone of oncological treatment. In parallel with technological advances in medicine, significant progress has also been achieved in surgical equipment. With the introduction of minimally invasive surgical techniques into general surgery practice, these methods have been increasingly adopted in cancer surgery. The ability of minimally invasive surgery to provide oncological outcomes comparable to conventional surgery, while improving patient comfort and attracting growing interest among surgeons, has contributed to the wider adoption of robotic surgery in clinical practice.

Results: Interest in robotic surgery for gastric cancer has been steadily increasing. It has been demonstrated that, with sufficient experience, robotic surgery allows for safe resections as well as effective and comprehensive lymph node dissections. Robotic gastrectomy has been reported to overcome the inherent limitations of conventional laparoscopic surgery by offering advantages such as complete tremor filtration, magnified three-dimensional high-definition stereoscopic vision, and enhanced instrument articulation

Conclusion: In this video presentation, we aimed to demonstrate the surgical procedure of a patient who underwent total gastrectomy for gastric cancer. Using a robotic surgical approach, the anatomical structures encountered during gastric cancer surgery and the lymph node dissection technique applied are planned to be shown in detail in the video.

Keywords: Robotic surgery, gastric cancer, total gastrectomy, lymph node dissection

[V-039]**A case of achalasia treated with robotic surgery: Video case presentation**Adem Akçakaya¹, Süleyman Atalay¹, Ercan Önder¹, Berde Ünyıldız¹, Uğur Arda¹, Emin Köse²

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Objective: Achalasia is a rare but severely impactful primary motor disorder requiring surgical treatment among esophageal motility disorders. While minimally invasive approaches have become standard practice, they present technical challenges due to the complexity of the esophageal-gastric junction anatomy. Robotic surgery has the potential to overcome these challenges with its advantages of three-dimensional vision, superior ergonomics, and precise dissection. This video presentation demonstrates in detail the robotic Heller myotomy technique, surgical steps, and critical points performed on a patient diagnosed with achalasia.

Material and Methods: This video presentation describes a patient diagnosed with achalasia who underwent robotic Heller esophageal myotomy and Dor fundoplication.

Results: A 44-year-old female patient with a known diagnosis of achalasia presented to our outpatient clinic with weight loss and dysphagia. Her history revealed that she had undergone balloon dilation approximately one year prior, but her symptoms persisted. Further investigations confirmed the diagnosis of achalasia. After completing preoperative preparations, robotic Heller esophageal myotomy and dorsal fundoplication were planned. After ensuring appropriate port placement and docking, exploration commenced. Following adequate retraction, the stomach was freed from posterior and omental adhesions. The hypertrophic muscle layer observed in the distal esophagus was dissected, exposing the mucosa. Dorsal fundoplication was performed, and endoscopic examination revealed complete mucosal integrity and adequate luminal patency. The operation was then completed after bleeding control and drain placement. The patient had no complications during postoperative follow-up and tolerated the prescribed diet, and was discharged without complications on the 4th postoperative day.

Conclusion: In the treatment of achalasia, surgery maintains its importance within different treatment plans. Heller myotomy, while the application of anti-reflux procedures is controversial, is considered the gold standard method. Among different surgical approaches, robotic surgery stands out compared to laparoscopy due to its advantages such as increased patient comfort in the postoperative period, stabilization in the use of surgical instruments, improved surgical field utilization, and the provision of three-dimensional vision. Robotic surgery can be safely applied in the treatment of achalasia.

Keywords: Robotic surgery, achalasia, minimally invasive

[V-041]**Robotic partial splenectomy**

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Objective: Partial splenectomy is increasingly preferred over total splenectomy for benign or indeterminate splenic lesions in order to preserve immunological function and reduce the risk of overwhelming post-splenectomy infection. However, the procedure remains technically demanding because of the risk of significant intraoperative bleeding. Robotic surgery offers enhanced dexterity, three-dimensional visualization, and precise vascular control, potentially facilitating parenchyma-sparing splenic surgery.

Material and Methods: We report a robotic partial splenectomy performed for a solitary, radiologically suspicious lesion located in the upper pole of the spleen. After patient positioning in a slightly right lateral decubitus position, a four-arm robotic approach was used. Selective dissection and ligation of the upper polar splenic arterial branches and short gastric vessels were performed to achieve segmental devascularization. To minimize blood loss additional clamping of the splenic artery and vein was performed using a bulldog clamp. The ischemic demarcation line was identified and confirmed intraoperatively. Parenchymal transection was carried out using the SynchroSeal energy devices combined with bipolar coagulation, followed by application of topical hemostatic agents. The resection specimen was extracted through a limited Pfannenstiel incision. A Blake drain was left in place.

Results: The procedure was completed without conversion. Blood loss was minimal and no postoperative complications occurred. The patient was discharged on postoperative day 3. Final histopathology confirmed a benign lesion with negative margins.

Conclusion: Robotic partial splenectomy is a safe and feasible spleen-preserving approach for selected splenic lesions, providing precise vascular control and excellent postoperative recovery.

Keywords: Robotic, splenectomy, partial

[V-042]**Minimally invasive enucleation of a giant esophageal leiomyoma: Surgical technique video presentation**

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Objective: Esophageal leiomyomas are the most common benign mesenchymal tumors of the esophagus and are usually small and asymptomatic. Giant esophageal leiomyomas are rare and may present significant technical challenges during surgical management. In this video presentation, we demonstrate the minimally invasive enucleation technique of a giant esophageal leiomyoma encircling the esophagus in a horseshoe configuration.

Material and Methods: A 40-year-old male patient with a giant esophageal mass originating from the distal esophagus was treated using a minimally invasive surgical approach. Under general anesthesia, the patient was positioned appropriately, and thoracoscopic access was obtained via right lateral ports. Dissection was initiated from the posterior aspect of the esophagus. Sharp and blunt dissection techniques were combined using energy devices and hook instruments. Particular attention was paid to preserving the integrity of the esophageal mucosa. The tumor was completely enucleated and retrieved using an endobag through an enlarged trocar site.

Results: Intraoperative findings revealed a solid mass approximately 10 cm in size encircling the esophagus in a horseshoe configuration. Complete enucleation was achieved without mucosal injury. The submucosal defect was closed with interrupted sutures, and thoracic drainage was performed. No intraoperative or postoperative complications were observed. The video highlights key steps of the procedure, including exposure, dissection planes, mucosal preservation, and safe tumor removal.

Conclusion: Minimally invasive enucleation of giant esophageal leiomyomas is a safe and effective surgical option when meticulous technique and mucosal preservation principles are applied. This surgical video aims to provide practical guidance for surgeons managing large and complex esophageal leiomyomas.

Keywords: Esophagus, leiomyoma, minimally invasive enucleation

[V-043]**EndoVAC therapy in delayed esophageal perforations associated with food impaction: Is it a valid option for all esophageal perforations?**

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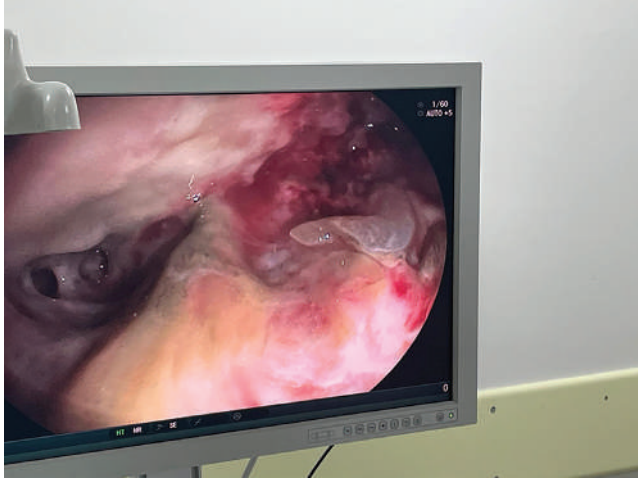


Figure 1. Mid-esophageal perforation.



Figure 2. Pre-discharge checkup.

[V-044]**Distal splenorenal (Warren) shunt in portal hypertension**

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Objective: Portal hypertension is one of the leading causes of variceal bleeding worldwide. Albeit more rarely performed, the distal splenorenal shunt (Warren's shunt) has proven to be effective in selectively decompressing the collateral circulation. DSRS (Warren shunt) is a critical surgical intervention for managing recurrent complications of PH especially in patients with in left sided PH with adequate hepatic function.

Material and Methods: Here, we review a case of non-cirrhotic portal hypertension manifesting with ascites and variceal hemorrhage treated with distal splenorenal (Warren) shunt.

Results: Sixty three years old male, body mass index: 20.4 kg/m². Medical history: Crohn disease, 6 years portal hypertension and 1.5 years ago gastroesophageal variceal bleeding and band ligation. Meld score: 9. Child score: 5/A. In January 2026, Warren procedure was performed.

Conclusion: Postoperative course: Unremarkable; discharged POD 4. Warren shunt procedure is an effective surgical procedure in non-chirrotic portal hypertension patients with variceal bleeding history and ascites. This procedure should be reserved for appropriately selected patients and performed exclusively by practitioners with substantial expertise.

Keywords: Portal hypertension, splenorenal Warren shunt

[V-045]**Endoscopic submucosal dissection for large colorectal lesions: A safe and effective approach**

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Objective: Colorectal cancer is one of the most common malignancies worldwide, and screening programs are widely implemented to reduce its incidence. As a result of these programs, detection rates of precancerous adenomas and early-stage carcinomas have increased. Excision of these lesions has been shown to significantly decrease the incidence of colorectal cancer. Therefore, the success of screening programs depends not only on lesion detection but also on the completeness and curative nature of endoscopic resection.

Material and Methods: Endoscopic submucosal dissection (ESD) is an advanced endoscopic technique that enables en-bloc resection of gastrointestinal lesions. Although it is a minimally invasive procedure, it has certain disadvantages, including the requirement for high technical expertise, relatively longer procedure times, and an increased risk of perforation. ESD is particularly recommended for colorectal lesions larger than 20 mm. Appropriate indications include lesions with suspected high-grade intraepithelial neoplasia or early cancer (such as non-granular type laterally spreading tumors, pseudodepressed or depressed morphology, and irregular surface patterns suggestive of early submucosal invasion), fibrotic lesions (e.g., sporadic adenomas arising in the setting of chronic inflammation such as ulcerative colitis), and residual neoplasia following previous endoscopic treatment.

Results: A 67-year-old male patient was referred to our center after a rectal mass was detected during evaluation for anemia. His medical history was notable for HBsAg positivity. Colonoscopy revealed a polypoid lesion approximately 5 cm in diameter located in the distal rectum, about 15 mm proximal to the dentate line. Based on the size and morphological characteristics of the lesion, ESD was planned. The lesion was elevated by submucosal injection of saline solution containing epinephrine. After marking the circumferential margins, a mucosal incision was performed, and the lesion was separated from the surrounding normal mucosa. Submucosal dissection was completed with repeated submucosal injections, and the lesion was resected en bloc. No intraoperative or postoperative complications were observed. Histopathological examination revealed a traditional serrated adenoma with foci of high-grade dysplasia. No adenomatous epithelium was identified at the resection margins.

Conclusion: ESD is an effective endoscopic treatment modality for large sessile or flat adenomas and for colorectal cancers with superficial or limited submucosal invasion, providing high en-bloc and curative resection rates with low recurrence rates. Despite its technical complexity and longer procedure times, favorable and safe outcomes can be achieved in appropriately selected patients when performed in experienced centers.

Keywords: Endoscopic submucosal dissection, rectal polyp, colonoscopy

[V-046]**ERCP in altered gastrointestinal anatomy: Balloon dilation without sphincterotomy in a patient with Billroth II gastrojejunostomy and Brown anastomosis**

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Objective: Choledocholithiasis is a common complication of gallstone disease, and endoscopic retrograde cholangiopancreatography (ERCP) currently represents the cornerstone of minimally invasive treatment. In patients with normal anatomy, stone extraction is typically performed using balloon or basket catheters following sphincterotomy. However, in patients with surgically altered anatomy, this standard approach may not always be feasible due to technical challenges. The presence of Billroth II gastrojejunostomy, particularly when combined with a Brown anastomosis, may reduce ERCP success rates by making identification of the afferent limb and access to the papilla more difficult.

Material and Methods: In patients with Billroth II gastrojejunostomy and Brown anastomosis following distal gastrectomy, ERCP becomes technically challenging due to anatomical alterations, sharp angulations, and adhesions. In cases where conventional sphincterotomy cannot be performed because of the reversed endoscopic view, endoscopic papillary large balloon dilation may be used as an alternative technique.

Results: A 65-year-old male patient with a history of hypertension and prior surgery for gastric cancer in 2020 was diagnosed with choledocholithiasis during outpatient evaluation. Gastroscopy revealed distal gastrectomy with Billroth II gastrojejunostomy and a Brown anastomosis. After identification of the afferent limb, the papilla was cannulated using a duodenoscope. Cholangioscopy confirmed the presence of two stones within the common bile duct. Due to the reversed orientation, sphincterotomy could not be performed; therefore, endoscopic papillary large balloon dilation was applied, and the stones were successfully extracted using a balloon catheter. A biliary stent was placed at the end of the procedure. Early postoperative laboratory findings remained within normal limits, and the stent was removed uneventfully at the eighth week.

Conclusion: ERCP can be successfully performed in experienced centers in patients with Billroth II gastrojejunostomy and Brown anastomosis. In cases where sphincterotomy is not feasible, endoscopic papillary large balloon dilation may be considered a safe and effective alternative technique.

Keywords: Endoscopic retrograde cholangiopancreatography, Billroth II gastrojejunostomy, Brown anastomosis

[V-047]**Synchronous gastric and jejunal phytobezoar: Endoscopic and surgical management**

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Objective: Bezoars are foreign bodies formed by the accumulation of indigestible materials within the lumen of the gastrointestinal tract. They are most commonly located in the stomach. Gastric bezoars develop due to the accumulation of various foods or medications in the stomach; they are indigestible and often fail to pass through the pylorus. Bezoars are classified into four main types according to their composition: Phytobezoars, trichobezoars, pharmacobezoars, and lactobezoars. Phytobezoars, the most common type, consist of indigestible plant fibers, fruit residues, peels, and seeds. They are typically observed in adults with a history of gastric surgery, decreased gastric acidity, or impaired gastric motility. Clinically, they may present with epigastric pain, nausea, vomiting, and symptoms of obstruction.

Material and Methods: Currently accepted treatment options for bezoars include observation, chemical dissolution, mechanical fragmentation, and surgical intervention such as laparotomy with gastrotomy. In addition, gastroscopic fragmentation, nasogastric lavage or suction, and enzymatic

therapy using agents such as cellulase and papain have been employed. Endoscopy has both diagnostic and therapeutic potential in the management of bezoars. However, endoscopic intervention may be technically challenging, and complications such as esophageal perforation have been reported in the literature.

Results: A 68-year-old female patient presented to the emergency department with a three-day history of nausea, vomiting, and abdominal pain. Her medical history was significant for appendectomy and prior abdominal surgery due to gastric ulcer (type of surgery unknown). Abdominal computed tomography revealed a 6×5 cm bezoar in the stomach and a second 3×3 cm bezoar causing proximal dilatation of a jejunal loop. A nasogastric tube was inserted, and medical management was initiated, followed by planned gastroscopy. Gastroscopy demonstrated a 6×5 cm phytobezoar impacted at the pylorus. After mobilization of the bezoar from the pylorus, deformation of the pyloric canal was observed. The bezoar was fragmented endoscopically using a snare. Control gastroscopy performed the following day showed a clear gastric lumen. However, as the ileus did not resolve during follow-up, the patient underwent surgery, and the jejunal bezoar was removed. The postoperative course was uneventful, and the patient was discharged in good condition.

Conclusion: Although gastric bezoars can often be successfully managed endoscopically, synchronous small bowel involvement may lead to persistent obstruction requiring surgical intervention. In patients with a history of gastric surgery, the possibility of multiple bezoars should be considered, and the entire gastrointestinal tract should be carefully evaluated.

Keywords: Gastric bezoar, jejunal bezoar, gastroscopy

[V-048]

Anatomical localization of parathyroid glands in parathyroidectomy: A video presentation

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Objective: A successful parathyroidectomy is fundamentally based on the accurate and safe localization of the parathyroid glands. Although preoperative imaging modalities such as ultrasonography and Tc-99m sestamibi scintigraphy play an important role in surgical planning, definitive localization is achieved through intraoperative anatomical knowledge and surgical experience. The embryological migration and anatomical variations of the parathyroid glands may complicate surgical exploration. In this video presentation, we aim to demonstrate the systematic intraoperative localization of the parathyroid glands according to their anatomical positions, guided by key surgical landmarks.

Material and Methods: In the video presentation, the step-by-step surgical exploration performed in patients undergoing parathyroidectomy for hyperparathyroidism is demonstrated. The locations of the superior and inferior parathyroid glands are presented in relation to key anatomical landmarks such as the recurrent laryngeal nerve, inferior thyroid artery, thyrothymic ligament, and the superior and inferior poles of the thyroid lobes. In addition to typical locations, potential ectopic sites are also highlighted. The surgical approach details the principles of capsular dissection, preservation of neurovascular structures, and the morphological features used to differentiate parathyroid glands from lymph nodes or adipose tissue.

Results: In the video presentation, the anatomical localization of the parathyroid glands was systematically evaluated using an eight-zone surgical classification system. Superior parathyroid glands were generally categorized within Zones I, II, III, and IV, whereas inferior parathyroid glands were classified within Zones V, VI, VII, and VIII. Among ectopic locations, intrathyroidal positioning (Zone IV) and the area between the carotid sheath and the esophagus inferior to the lower pole of the thyroid gland (Zone VIII) were demonstrated. It was emphasized that knowledge of the embryological descent pathway facilitates surgical exploration, particularly in regions such as Zones VII and VIII. The zone-based systematic exploration approach was observed to contribute to faster identification of the glands and to reduce the need for unnecessary extensive dissection. This approach was also considered to enhance preservation of the recurrent laryngeal nerve and improve overall surgical safety.

Conclusion: A thorough understanding of surgical anatomy is fundamental to safe and effective parathyroidectomy. Although imaging modalities provide valuable guidance, definitive localization is achieved through intraoperative anatomical expertise. This video presentation aims to provide surgeons with a practical and systematic, landmark-based approach to the anatomical localization of the parathyroid glands, serving as a surgical roadmap. It represents an educational resource particularly for surgeons in training and may contribute to improving the success of surgical exploration.

Keywords: Anatomical localization, parathyroid glands, parathyroidectomy

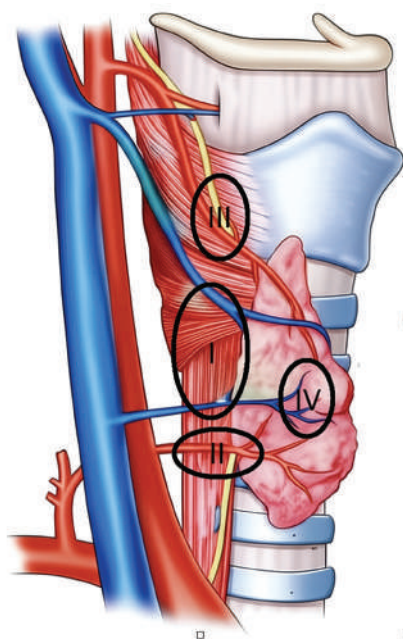


Figure 1. Anatomical sites of superior parathyroid glands.

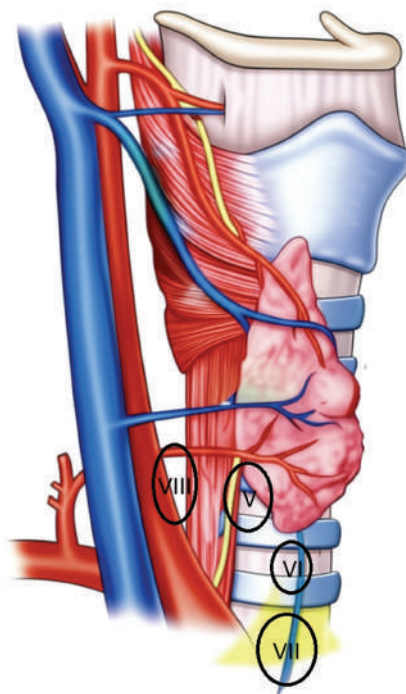


Figure 2. Anatomical sites of inferior parathyroid.

[V-049]**A rare tumor of the adrenal gland: Anastomosing hemangioma**Furkan Dağkaya, Fatih Kocalar, Fahrettin Acar, Ahmet Furkan Bulut*Selçuk University Faculty of Medicine Hospital, Konya*

Objective: The adrenal gland, composed of the cortex and medulla, can give rise to a variety of benign and malignant lesions. While adrenal adenoma is the most common, other pathologies such as cystic lesions, hemangiomas, sarcomas, lymphomas, and adrenocortical carcinoma have been reported. Among these, anastomosing hemangioma, a rare vascular tumor, has been described in several locations, including the abdominal and paraspinal regions, the genitourinary system, and the mediastinum.

Material and Methods: We report a 34-year-old female who presented with right lumbar pain. Contrast-enhanced computed tomography revealed a 47×57 mm heterogeneous lesion at the right adrenal gland. The lesion showed heterogeneous enhancement in the arterial and portal venous phases, with mild washout on delayed imaging and an absolute washout index of 13, raising suspicion for a clinically significant adrenal mass.

Results: The patient was normoglycemic and normotensive, with normal electrolytes. Hormonal evaluation confirmed a non-functioning lesion. Due to its size and associated pain, surgical excision was performed. The mass

was removed laparoscopically along with the right adrenal gland, and the patient was discharged uneventfully on postoperative day 1. No recurrence was observed during follow-up, and histopathology confirmed anastomosing hemangioma.

Conclusion: First described by Montgomery and Epstein in 2009, anastomosing hemangioma is a benign tumor with histopathological features resembling angiosarcoma. Tao et al. reported its occurrence in the kidneys, perinephric fat, liver, ovaries, small intestine, and adrenal gland. Most tumors arise in the retroperitoneum, and patients are frequently asymptomatic, with lesions detected incidentally. Clinical features may include hematuria, back or abdominal pain, hematoma, and lower urinary tract symptoms, whereas extra-renal lesions may present with a palpable mass, localized pain, neurological deficits, or pleural effusion. Due to its rarity, specific radiologic characteristics are not well established. Although it may mimic angiosarcoma, anastomosing hemangioma generally exhibits minimal irregular growth without the diffuse infiltrative pattern of angiosarcoma. Histologic features supporting its benign nature include lobular architecture, association with medium-sized vessels, hobnail endothelial cells, and absence of significant cytologic atypia. In summary, adrenal anastomosing hemangioma is a rare benign vascular tumor. Because imaging and biochemical studies cannot reliably distinguish it from malignancy, surgical excision is often necessary. This case emphasizes the importance of considering anastomosing hemangioma in the differential diagnosis of adrenal masses to guide appropriate management.

Keywords: Adrenal gland, anastomosing hemangioma

[V-050]

Treatment of a patient with pheochromocytoma in MEN 2A syndrome with cortex-sparing surgeryÖnder Özcan, Narmin Hajizada, Oğuz Çatal, Harun Ölmez

Muğla Sıtkı Koçman University Faculty of Medicine, Muğla

Objective: Multiple endocrine neoplasia type 2A (MEN 2A) syndrome is a rare endocrine neoplasia syndrome with autosomal dominant inheritance and associated with mutations in the RET proto-oncogene. MEN 2A-related pheochromocytomas are mostly benign. Clinically, they carry a high risk of morbidity and mortality due to hypertensive crises, arrhythmias, and cardiovascular complications caused by excessive catecholamine release. Surgical treatment is the fundamental and curative approach in the management of pheochromocytoma. While traditional adrenalectomy leads to adrenal insufficiency, cortex-sparing surgery is an alternative approach aimed at preserving adrenal function.

Material and Methods: In this study, a cortex-sparing adrenal surgical approach was evaluated in a patient with MEN 2A and pheochromocytoma. The diagnosis was confirmed by clinical findings, biochemical tests, and radiological imaging. Tumor localization, size, and adrenal involvement were assessed by CT, MRI, and DOTA-PET, revealing a functional right-sided lesion measuring 19×17 mm, while the left adrenal gland was normal. Preoperatively, alpha-adrenergic blockade was administered according to standard protocols, beta-blockers were added, fluid-electrolyte balance was optimized, and perioperative planning was performed with the anesthesia team. Complete tumor excision was achieved with maximal preservation of adrenal cortical tissue. Postoperatively, hemodynamic parameters, electrolytes, and serum cortisol levels were closely monitored. Adrenal function was assessed using combined clinical and laboratory evaluations, and the need for steroid replacement therapy was observed during follow-up.

Results: The surgical procedure was completed without complications. The patient did not experience a hypertensive crisis or significant hemodynamic instability in the postoperative period. Postoperative serum cortisol levels

were found to be adequate, and routine glucocorticoid or mineralocorticoid replacement therapy was not required. Thanks to the preserved adrenal cortex, the patient did not develop clinical or biochemical signs of adrenal insufficiency and did not require steroid replacement therapy.

Conclusion: In this case, cortex-sparing adrenal surgery preserved sufficient adrenal cortical tissue, allowing continued endogenous steroid hormone production and preventing the development of adrenal insufficiency. Early clinical and biochemical outcomes suggest that this approach can be a safe and effective option in appropriately selected patients. Its main advantage is the reduction of complications related to lifelong hormone replacement therapy and the risk of adrenal crisis. When performed with careful patient selection, by experienced surgeons, and with regular long-term follow-up, cortex-sparing adrenal surgery in patients with MEN 2A-associated pheochromocytoma may be considered an important surgical alternative that improves quality of life within a multidisciplinary and individualized treatment framework.

Keywords: MEN 2A syndrome, pheochromocytoma, cortex-sparing adrenalectomy, partial adrenalectomy, laparoscopic adrenalectomy

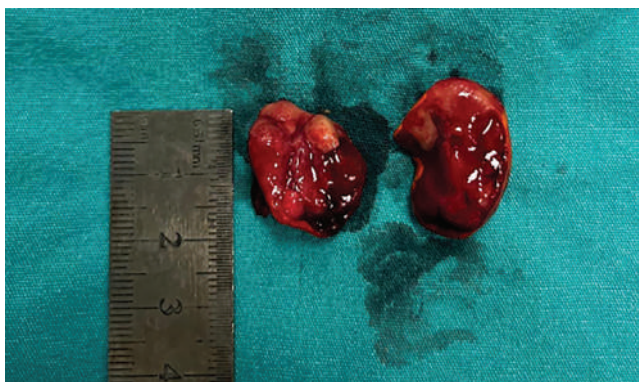


Figure 1. Size and cut surface of the excised specimen.

Table 1. Laboratory parameters preoperative-postoperative values

	Preop value	Postop value	Normal value
ACTH	10.9 pg/mL	11.1	7.2-63.3 pg/mL
Cortisol (a.m)	9.7 µg/dL	10.5 µg/dL	6.2-18.4 µg/dL
DHEAS	122 ug/dL	118 ug/L	98.8-340 ug/dL
(24-hour urine test)			
Metanephrine	471 µg/day		24-96 µg/day
Normetanefrin	457 µg/day		75-375 µg/day
Homovanilic acid	11.7 mg/24 h		1.5-8.0 mg/24 h
VMA	7.8 mg/24 h		0.4-6.5 mg/24 h

[V-051]**A simplified and secure specimen retrieval technique in laparoscopic liver surgery**İsmail Hasırcı, Rıdvan Kurt, Muhammed Emin Şahin, Adil Kartal*University of Health Sciences Türkiye, Konya City Hospital, Konya*

Objective: Laparoscopic liver resections are being performed with increasing frequency. Beyond the safety of the operation itself, the laparoscopic placement of the resected liver segment into an endobag and its extraction from the abdomen are technically significant steps. In specimens with bulky or fragile parenchyma, this stage can lead to time loss, parenchymal damage, or endobag rupture. We present our technical approach for the easy and controlled retrieval of the resection material into the endobag in a case of laparoscopic left lateral segmentectomy for a lesion located in segments 2-3.

Material and Methods: A 27-year-old female presented with a 2-year history of postprandial nausea, vomiting, and epigastric pain. Laboratory tests, including liver function and tumor markers, were normal. Ultrasonography revealed a 48 mm hypoechoic lesion in the left lobe. Dynamic liver MRI showed a solid lesion in segments 2-3 with arterial phase enhancement and no washout in the late phase, which was atypical for hemangioma or HCC. Following a general surgery multidisciplinary meeting, a laparoscopic left lateral segmentectomy was planned. After port placement, the falciform ligament was mobilized. The left lateral segment was divided up to the

junction of the left triangular and coronary ligaments using Ligasure. Parenchymal transection was completed flush with the falciform ligament using thermal energy devices and endostaplers. The specimen was left suspended by a 2 cm attachment. The following retrieval technique was applied: After transection, the specimen remained suspended by the coronary ligament, preventing it from falling into the abdominal cavity. The endobag was fully opened and positioned directly beneath the specimen. Utilizing the advantage of suspension, the specimen was guided into the bag with minimal atraumatic manipulation, avoiding direct parenchymal grasping. Once the specimen was inside the bag, the coronary ligament was divided, and the bag was extracted via a 4-5 cm incision in the left upper quadrant.

Results: Histopathology revealed focal nodular hyperplasia. Specimen retrieval is often overlooked in the literature but significantly impacts practice. In bulky resections like the left lateral segment, uncontrolled manipulation may cause parenchymal fragmentation. Our technique of utilizing gravity and suspension shortens retrieval time and enhances safety. A similar method was applied by Cakir et al. (2013) in laparoscopic splenectomy.

Conclusion: During this technique, the resected liver segment can be safely and easily placed into the endobag through manipulation. The technique presented can be considered a method that facilitates the surgical flow, shortens the duration of surgery, and reduces the risk of complications.

Keywords: Laparoscopic, left lateral segmentectomy, endobag

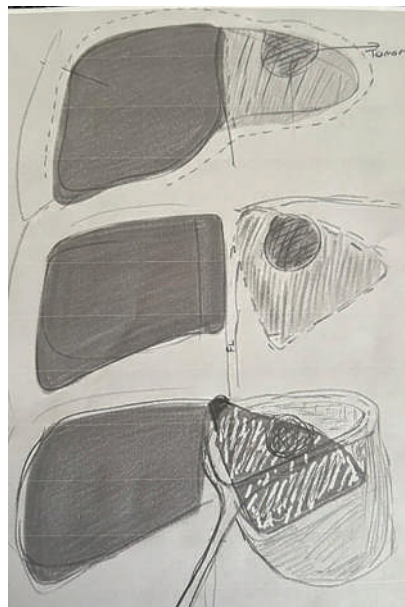


Figure 1. Technical drawing.

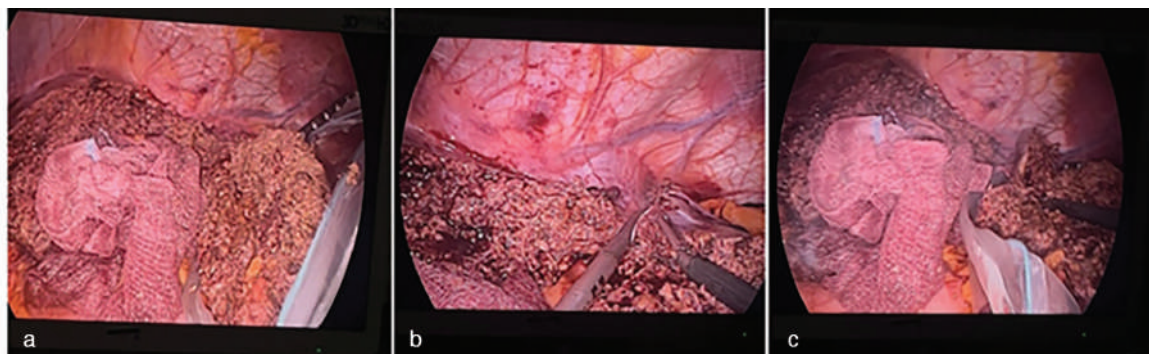


Figure 2. a) Placement of the specimen into the endobag, b) Cutting of the coronary ligament, c) Complete placement of the specimen into the endobag and closure of the endobag.

[V-052]**A safe strategy for difficult gallbladder surgeries:
Laparoscopic subtotal cholecystectomy**

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Objective: Laparoscopic subtotal cholecystectomy (LSC) is an important alternative strategy to avoid serious complications in situations when the “critical view of safety” principles cannot be met. In this study, we evaluated the outcomes of LSC in severe cholecystitis cases where dissection of the gallbladder duct and bile artery is dangerous.

Material and Methods: In our clinic, out of a total of 313 cholecystectomy surgeries performed between January 2022 and January 2026, 27 were treated using the LSC technique. We aim to present videos of four of these cases.

Results: Of the four patients we will present, three had undergone ERCP and one had percutaneous cholecystostomy. One patient with ERCP also had common bile duct stones. Intraoperative cholangiography was performed on three patients. In two patients, the gallbladder stump was closed with staples, while in the others it was closed with sutures. No bile leakage occurred in any case. All patients were discharged without complications.

Conclusion: LSC is an effective technique that can be applied in cases where cholecystohepatic dissection cannot be performed, clear visualization cannot be achieved, or the cystic duct cannot be clearly visualized. Avoiding bile duct injury and not having to switch to open surgery are important advantages.

Keywords: Acute cholecystitis, critical view of safety, laparoscopic subtotal cholecystectomy, tough cholecystectomy

[V-053]**Laparoscopic organ-preserving resection for pancreatic surface-located duodenal GIST**

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Objective: Duodenal gastrointestinal stromal tumors are rare lesions with incompletely defined prognostic features and recurrence patterns. Complete surgical resection with negative margins remains the main curative treatment; however, the optimal surgical approach has not been clearly established. Surgical strategy is determined by tumor size and anatomical location, particularly in relation to critical structures such as the pancreatic head, common bile duct, ampulla, and mesenteric root. Minimally invasive surgical techniques are increasingly used in current clinical practice. In this report, we present a laparoscopic excision of a GIST located in the second portion of the duodenum.

Material and Methods: A 34-year-old male patient presenting with dyspeptic symptoms underwent upper gastrointestinal endoscopy at the referring center. Endoscopy revealed a subepithelial lesion approximately 3 cm in diameter with central ulceration, located in the second portion of the duodenum about 1 cm proximal to the major papilla, and biopsy samples were obtained. Histopathological evaluation showed inactive, moderately chronic duodenitis without evidence of a submucosal lesion. Subsequently EUS demonstrated a hypervascular mass measuring approximately 35 mm, presumed to originate from the deep muscular layer of the duodenum and extending toward the pancreatic head. Fine-needle aspiration biopsy confirmed the diagnosis of gastrointestinal stromal tumor with a mitotic count of 1/10 high-power fields. Upper abdominal magnetic resonance imaging revealed a homogeneously enhancing solid mass measuring 2.5×3.5×2.5 cm. Neoadjuvant imatinib therapy (400 mg/day) was initiated. Follow-up imaging demonstrated tumor regression to 12×21 mm with reduced compression of adjacent structures. Positron emission tomography showed resolution of previously observed low-level FDG uptake. The patient was referred for surgical management.

Results: Duodenoscopy under general anesthesia demonstrated that the lesion was located approximately 2 cm from the papilla and was not suitable for endoscopic resection. The lesion was marked with metal clip and the peripapillary region was stained. Laparoscopic duodenotomy was performed and the tumor was excised with clear surgical margins. Postoperatively, transient fever attributed to atelectasis and temporary elevations in bilirubin and amylase/lipase levels were observed, which resolved with medical management. The patient was discharged on postoperative day 6. Final pathological examination revealed a well-circumscribed gastrointestinal stromal tumor involving the submucosa and muscularis propria, with moderate cellularity and no significant atypia. The mitotic index was 0/5 mm² and Ki-67 was <1%, indicating low malignant risk. Due to microscopic involvement at the basal resection margin, adjuvant imatinib therapy was initiated.

Conclusion: Minimally invasive resection provides favorable outcomes in selected duodenal GISTs.

Keywords: Duodenal GIST, laparoscopic excision, duodenotomy

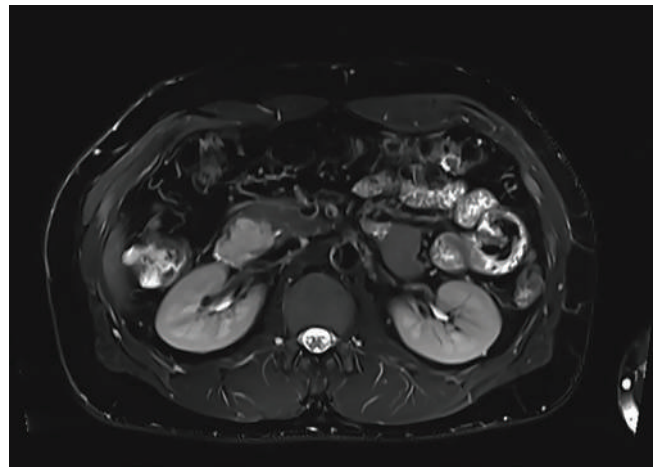


Figure 1. Baseline MRI image.

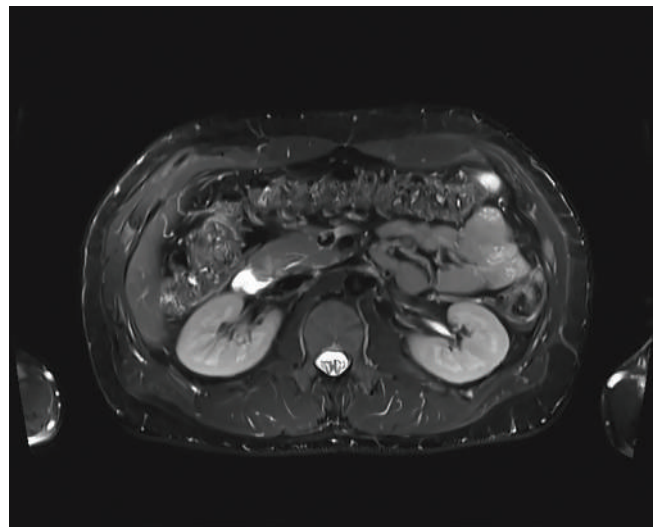


Figure 2. Post-neoadjuvant MRI.

[V-054]**Transanal minimal invasive surgery (TAMIS) in early-stage rectal adenocarcinoma: Technical details**

Ümit Cem Soydaş, Bahaeddin Umur Aka, Enise Bacak, Alp Ömer Cantürk, Erhan Eröz

Department of General Surgery, Sakarya University Training and Research Hospital, Sakarya

Objective: Transanal minimally invasive surgery (TAMIS) is a modern surgical technique developed for the local excision of rectal pathologies. TAMIS was developed to overcome the limitations of traditional methods such as transanal endoscopic microsurgery (TEM) and is performed using standard laparoscopic instruments through a single port or SILS port. The technique was first described in 2010. The most common indications for TAMIS are: •Benign adenomatous lesions: adenoma, villous/tubulovillous polyp, etc. •Early-stage rectal cancers: T1 (especially low-risk) - in selected cases. •Other rare pathologies: neuroendocrine tumors, gastrointestinal stromal tumor, etc. •Lesion size and spread: traditionally <3 cm and <30% circumferential, but larger or circumferential lesions have also been successfully removed with increasing experience.

Material and Methods: The records of patients who underwent TAMIS at the General Surgery Clinic of Sakarya Training and Research Hospital between 2023 and 2026 were retrospectively evaluated.

Results: Eleven patient files were evaluated within the scope of the study. Three (27.27%) of the patients were female and eight (72.72%) were male. In this video presentation, our latest case reflecting our experience will be shared in detail. Case 49-year-old female patient presented with rectal bleeding. Colonoscopy revealed a 3 cm lesion at 5 cm in the rectum, with a depressed center and a Paris 0-2a+c pattern. The image was evaluated as suggestive of possible malignancy. A biopsy was planned. Histopathological examination showed well-differentiated adenocarcinoma developed on a villous adenoma base with negative margins. The patient's postoperative course was uneventful. She was referred to oncology.

Conclusion: TAMIS is a safe, effective, and minimally invasive excision for selected benign and early-stage malignant rectal lesions. Clinical outcomes demonstrate low morbidity, R0 resection, and low local recurrence in well-selected cases. The technique is an effective method in current colorectal surgical practice with proper patient selection and appropriate preoperative evaluation.

Keywords: Minimally invasive surgery, early-stage rectal cancer



Figure 1.

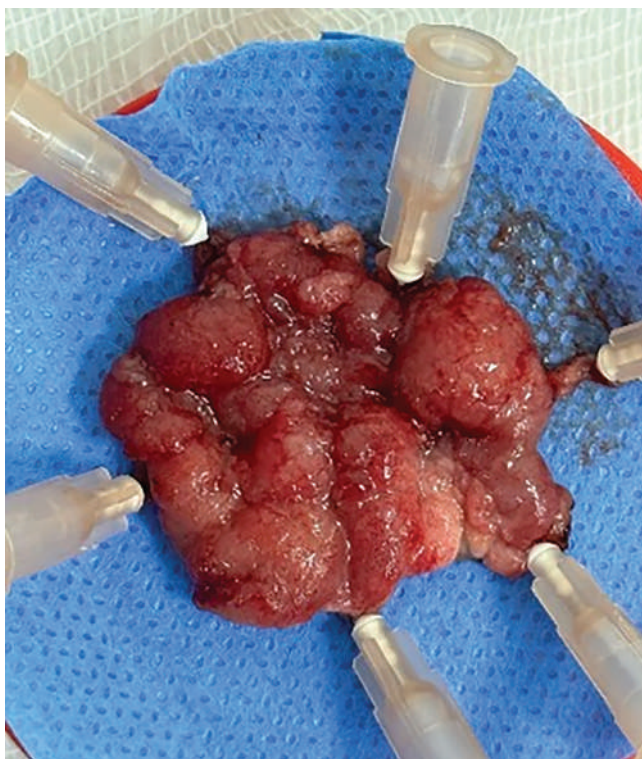


Figure 2.

[V-055]**Our experience with laparoscopic approach in rectus diastasis: Video presentation**Adem Akçakaya, Süleyman Atalay, Uğur Arda, Ercan Önder, Berde Ünyıldız*Department of General Surgery, Bezmialem Vakıf University, İstanbul*

Objective: Rectus diastasis is an abdominal wall deformity characterized by the pathological separation of the rectus abdominis muscles along the midline linea alba. While not a true hernia, it can lead to significant bulging of the anterior abdominal wall, cosmetic problems, and functional complaints in some patients. It is most common in post-pregnancy women, but can also be associated with obesity, rapid weight changes, advanced age, and increased intra-abdominal pressure. The clinical approach varies depending on the patient's symptoms, the presence of a concomitant ventral hernia, and cosmetic expectations. Conservative treatment options include exercise and physiotherapy, while surgical repair may be performed in symptomatic or advanced cases. In recent years, various surgical approaches, including open, laparoscopic, and robotic techniques, have been described, and the optimal treatment choice should be evaluated on a case-by-case basis.

Material and Methods: A 49-year-old male patient, who had been complaining of abdominal swelling for approximately two years, was diagnosed with an umbilical hernia and accompanying rectus diastasis upon examination. Your video presentation shows the laparoscopic surgical procedure performed on the patient.

Results: A 63-year-old male patient with no known underlying medical conditions presented to our outpatient clinic with complaints of swelling and pain. Examination revealed an umbilical hernia and rectus diastasis. Laparoscopic repair was planned. Following preoperative staining and skin measurements, the camera and working ports were inserted through the left quadrant. The anterior abdominal wall was prepared for plication in the midline. Then, starting superior to the diastasis area, the diastasis area was plied with V-lock sutures, and the umbilical hernia defect was repaired. Dual mesh was adjusted to the appropriate size based on the skin contours. The intra-abdominal projections of the contours were checked. Suspension sutures were placed at designated points on the mesh, and it was then advanced into the abdominal cavity. The suspension sutures were brought out and tied using an Endoclose needle, and the mesh was secured to the abdominal wall. The mesh was secured with Tuckers, and after bleeding control, the procedure was completed. The patient was followed up without complications in the postoperative period and was scheduled for discharge on the second postoperative day.

Conclusion: This case report shows the laparoscopic surgery planned for a patient with umbilical hernia and rectus diastasis. With appropriate patient selection and surgical planning, it has been observed that both functional complaints decrease and effective cosmetic results are achieved.

Keywords: Rectus diastasis, laparoscopy, hernia

[V-056]**Laparoscopic ladd procedure for organoaxial partial rotation anomaly: A video presentation**Tarık Yılmaz¹, İsmet Canpunar¹, Eda Karakaya¹, Ali Karataş², Çağrı Büyükkasap¹¹*Department of General Surgery, Gazi University Faculty of Medicine, Ankara*²*Department of Gastroenterology, Gazi University Faculty of Medicine, Ankara*

Objective: Intestinal rotational anomalies represent a broad spectrum of developmental disorders resulting from varying degrees of incomplete rotation and fixation of the midgut during embryologic development. Partial rotation anomalies and abnormal positioning of the duodenojejunal junction rarely become symptomatic in adulthood and often mimic functional gastrointestinal diseases. Because clinical findings are typically chronic and non-specific, diagnosis may be delayed. This video presentation aims to demonstrate the laparoscopic surgical management of an adult patient diagnosed with organoaxial partial rotation anomaly and duodenojejunal junction malposition.

Material and Methods: A 23-year-old female presented with intermittent abdominal pain, nausea, vomiting, and dyspeptic symptoms that began after riding a roller coaster. She had experienced an unintended weight loss of approximately 21 kg over the preceding year. Upper gastrointestinal endoscopy revealed torsion at the third portion of the duodenum with inability to advance distally. Computed tomography demonstrated an abnormal course of the duodenum, malposition of the duodenojejunal junction, and proximal duodenal dilatation. These findings were considered consistent with an organoaxial partial rotation anomaly. The case was discussed in a multidisciplinary meeting, and surgical treatment was recommended. The procedure was performed laparoscopically using one 10-mm optical trocar and two 5-mm working trocars. The right colon was mobilized, and careful dissection along the mesenteric root was carried out to broaden the mesenteric base. The duodenum was mobilized using a Kocher maneuver, releasing the structures affecting the duodenojejunal junction. The bowel was placed in a tension-free functional position, and a prophylactic appendectomy was performed.

Results: No acute midgut volvulus was identified intraoperatively. The clinical presentation was attributed to the abnormal positioning of the duodenojejunal junction. The postoperative course was uneventful. The patient resumed oral intake and was discharged without complications on postoperative day 3. During follow-up, gastrointestinal symptoms markedly improved, and a 9-kg weight gain was observed at postoperative month 8.

Conclusion: Organoaxial partial rotation anomaly with duodenojejunal junction malposition is a rare but important cause of chronic upper gastrointestinal obstruction in adults. Clinical awareness is essential to prevent diagnostic delay. The laparoscopic Ladd procedure provides a safe and effective treatment by relieving duodenal compression and broadening the mesenteric base.

Keywords: Intestinal malrotation, Ladd procedure, laparoscopic surgery

[V-057]**Emergency laparoscopic collis gastroplasty in a geriatric patient with giant hiatal hernia: A video case report**

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Objective: To present the experience of laparoscopic Collis gastroplasty performed under emergency conditions in an elderly patient with a giant hiatal hernia who presented with acute symptoms, having previously refused elective surgery due to advanced age and additional risks.

Material and Methods: An 84-year-old female patient presented to the emergency department with complaints of abdominal pain and nausea. The patient denied vomiting, and passage of gas and stool was present. Her medical history was unremarkable except for hypertension. It was learned that she had a diagnosis of giant hiatal hernia and elective surgery had been recommended, but she had refused the operation due to advanced age and associated risks. Physical examination revealed tenderness in the epigastric region; however, signs of acute abdomen (guarding, rebound tenderness) were not detected. Laboratory findings showed WBC: 4.95 K/uL, Hgb: 13.4 g/dL, and CRP: 1.43 mg/L. Blood gas analysis revealed pH: 7.24, PCO₂: 40.4 mmHg, lactate: 1.7 mmol/L, and HCO₃: 26 mmol/L. Computed tomography demonstrated a giant hiatal hernia.

Results: Gastroscopy was performed on the admitted patient to rule out gastric ischemia, and no ischemic areas were visualized. Due to the persistence of symptoms, the decision was made to proceed with surgery. The patient underwent laparoscopic Collis gastroplasty. She was admitted to the intensive care unit for postoperative monitoring. On the first postoperative day, as her condition remained stable, she was transferred to the ward. The patient, who tolerated oral intake and showed no acute pathology during follow-up, was discharged with recommendations on the fifth postoperative day.

Conclusion: Even if elective surgery has been refused in cases of giant hiatal hernia, laparoscopic Collis gastroplasty should be considered a safe treatment option for geriatric patients presenting with acute symptoms and risk of incarceration, as it provides anatomical correction and shortens the duration of intensive care and hospital stay.

Keywords: Giant hiatal hernia, collis gastroplasty, laparoscopy, minimally invasive surgery

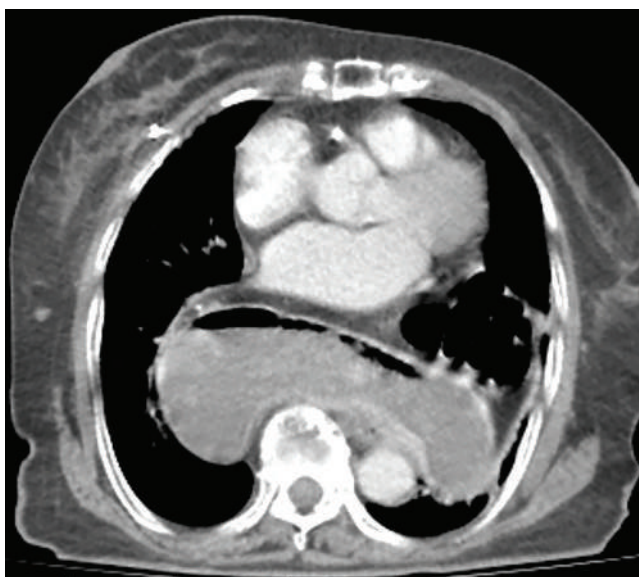


Figure 1. Appearance of giant hiatal hernia on CT, coronal section.



Figure 2. Appearance of giant hiatal hernia on CT, axial section.

[V-058]**House flap anoplasty in the treatment of chronic anal fissure**

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Objective: Chronic anal fissure is one of the most common benign diseases of the anal canal and is usually associated with internal anal sphincter hypertonia. However, in some patients, internal anal sphincter tone may be decreased, which can influence the choice of surgical treatment. Although lateral internal sphincterotomy has high healing rates in the treatment of chronic anal fissure, it may be limited by the risk of anal incontinence, particularly in female patients and those with an obstetric history. Therefore, sphincter-preserving surgical techniques have emerged as an important alternative in selected patient groups. The aim of this study is to present the house flap anoplasty technique performed in a patient with chronic anal fissure resistant to medical treatment and botulinum toxin injections.

Material and Methods: A 50-year-old female patient with a history of four vaginal deliveries, who did not respond to medical treatment and repeated botulinum toxin injections, was included in the study. Preoperative physical examination revealed a posterior chronic anal fissure with a sentinel pile and a chronic ulcer extending to the internal anal sphincter fibers. Digital rectal examination demonstrated decreased internal anal sphincter tone. The patient was operated on in the lithotomy position. Following fissurectomy, the defect was closed using a house advancement flap. In order to achieve adequate mobilization of the flap, a portion of the superficial external anal sphincter fibers was carefully released. No incision was made to the internal anal sphincter. The flap was closed using absorbable sutures.

Results: No intraoperative or early postoperative complications were observed. Flap perfusion was assessed as adequate. During postoperative follow-up, wound healing was uneventful and a significant improvement in fissure-related symptoms was achieved. No signs of anal incontinence were observed. The patient remained clinically stable during follow-up.

Conclusion: In chronic anal fissure cases resistant to medical treatment and botulinum toxin injections, particularly in patients with hypotonic internal anal sphincter and an obstetric history, house flap anoplasty may be considered an effective sphincter-preserving surgical option. Closure of the fissurectomy defect with a well-vascularized flap provides a reconstructive approach that supports healing while preserving anal continence.

Keywords: Chronic anal fissure, fissurectomy, house flap anoplasty, sphincter-preserving surgery, hypotonic internal anal sphincter

[V-059]**Anal stenosis following hemorrhoidectomy: Is there a way out?**

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Objective: Anal stenosis following hemorrhoid surgery represents one of the most disabling iatrogenic complications in benign colorectal disease. Although uncommon, its impact on bowel function, quality of life, and subsequent surgical complexity is profound. The condition is largely preventable, yet once established, management requires a nuanced understanding of anorectal anatomy, wound healing, and reconstructive principles. This video vignette critically examines the pathophysiology, prevention, and contemporary surgical management of post-hemorrhoidectomy anal stenosis, challenging the misconception that it constitutes a therapeutic dead end.

Material and Methods: This structured video-based presentation integrates surgical anatomy, mechanism-based classification, and real-world operative decision-making derived from complex clinical cases of post-hemorrhoidectomy and post-stapled hemorrhoidopexy anal stenosis. Preventive strategies during primary hemorrhoidal surgery, diagnostic work-up including endoscopic assessment, and a stepwise treatment algorithm are demonstrated. Surgical techniques include dilation protocols, mucosal and cutaneous advancement flaps, island flaps, and rotational reconstructions (house, diamond, and S-plasty), with emphasis on indications, technical nuances, and reconstructive principles rather than procedural dogma.

Results: Conservative measures may provide symptom relief in mild stenosis but may contribute to further anodermal injury when overused. Definitive management of moderate to severe stenosis requires surgical reconstruction aimed at restoring a compliant anal canal with well-vascularized tissue. Local advancement flaps are effective for focal disease, whereas extensive, circumferential, or recurrent stenosis necessitates rotational flap techniques. Among these, the house flap demonstrates broad applicability across stenosis types, technical reliability, and favorable functional outcomes when principles of adequate mobilization, preservation of perfusion, and tension-free closure are strictly respected. Failure patterns were consistently associated with excessive primary excision, loss of skin bridges, and surgery performed in the acute inflammatory phase.

Conclusion: Post-hemorrhoidectomy anal stenosis is not an inevitable complication nor an unsolvable problem. Its occurrence reflects technical and conceptual errors in the treatment of a benign disease. Prevention through limited excision and respect for anodermal integrity remains paramount. When reconstruction is required, successful outcomes depend less on flap selection than on adherence to fundamental reconstructive principles and surgeon familiarity with the chosen technique. Ultimately, hemorrhoidal disease should never be managed with oncologic aggressiveness—doing so transforms a benign condition into a lifelong surgical burden.

Keywords: Anal stenosis, hemorrhoidectomy, reconstructive surgical procedures

[V-061]**Anatomical variation of the middle colic artery in robotic right hemicolectomy**

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Objective: Complete mesocolic excision (CME) with central vascular ligation (CVL) is essential for optimal oncologic outcomes in right-sided colon cancer. Variations of the middle colic artery (MCA) may significantly influence the surgical strategy, particularly in tumors involving the hepatic flexure and proximal transverse colon. The robotic platform, with its enhanced three-dimensional visualization and articulating instruments, may facilitate safe management of complex vascular anatomy. In this video, we present a robotic right hemicolectomy performed in a patient with a MCA variation.

Material and Methods: A standard medial-to-lateral approach was employed, and the ileocolic vessels were centrally ligated. Careful dissection was performed along the anterior aspect of the superior mesenteric artery and superior mesenteric vein. The variation of the MCA was identified using indocyanine green fluorescence imaging, and the anatomical course of the vascular structures was confirmed. CME and CVL were accomplished in accordance with oncologic principles. An intracorporeal anastomosis was subsequently performed.

Results: The variant branching pattern of the MCA was clearly identified intraoperatively, allowing safe vascular control. The robotic system enabled precise dissection without major vascular complications. Adequate surgical margins and appropriate lymph node harvest were achieved.

Conclusion: MCA variations are important anatomical considerations that may alter the surgical strategy during robotic right hemicolectomy. The robotic platform facilitates safe and oncologically sound management of such vascular variations. Careful preoperative vascular assessment and meticulous medial dissection are crucial to minimize intraoperative complications.

Keywords: Anatomical variation of the middle colic artery, robotic right hemicolectomy, ICG

[V-062]**Robotic low anterior resection in locally advanced upper rectal cancer following neoadjuvant chemotherapy: Technical details**Serra Bayrakceken¹, Çiğdem Benlice², Afag Aghayeva³, Emra Baca⁴, Bilgi Baca¹¹Department of General Surgery, Acıbadem Mehmet Ali Aydınlar University Faculty of Medicine, Istanbul²Department of General Surgery, Istanbul Health and Technology University Faculty of Medicine, Istanbul³Clinic of General Surgery, Acıbadem Altunizade Hospital, Istanbul⁴Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Istanbul

Objective: Robotic surgery has become an important approach in rectal cancer surgery, offering enhanced visualization and precision, particularly in confined spaces such as the pelvis. This video demonstrates the key steps and technical details of a robotic low anterior resection in a patient with locally advanced upper rectal cancer after neoadjuvant chemotherapy on the da Vinci Xi robotic platform.

Material and Methods: A 61-year-old male presented with changes in bowel habits. Colonoscopy revealed a circumferential mass causing luminal narrowing extending from 10 to 17 cm from the anal verge. Biopsy confirmed adenocarcinoma. Pelvic MRI demonstrated a rectosigmoid junction tumor located in the upper rectum, with limited perirectal extension. Ten locoregional lymph nodes were identified, the largest measuring 8 mm. Presacral fascial planes were preserved. Following six cycles of neoadjuvant FOLFIRINOX, imaging revealed a complete metabolic response in the perirectal lymph nodes and a partial response in the rectosigmoid tumor. Robotic low anterior resection was planned.

Results: Surgery was initiated with incision at the sacral promontory. Rectal mobilization was performed along the embryological "holy plane" using sharp dissection. Both right and left hypogastric nerves were identified and preserved during medial-to-lateral dissection. Intermesenteric anastomosis was detected and clipped. The inferior mesenteric artery was clipped approximately 1 cm distal to its origin from the aorta, with preservation of the inferior mesenteric plexus. The inferior mesenteric vein was divided below the pancreas, and dissection proceeded along the superior border of the pancreas to enter the lesser sac. Complete mobilization of the splenic flexure was achieved. Anterior pelvic dissection was initiated by incising the anterior peritoneal reflection. After completion of the anterior dissection, the posterior plane was entered and posterior pelvic dissection was completed. Following complete mobilization, rectal transection was performed using a robotic stapler. An end-to-end colorectal anastomosis was completed using a circular stapler. Anastomotic integrity was confirmed with an air leak test.

Conclusion: This video highlights that a fully robotic low anterior resection enables controlled and precise dissection in the narrow pelvic cavity, improves surgical ergonomics, and provides a safe approach to upper rectal cancer surgery after neoadjuvant chemotherapy.

Keywords: Robotic surgery, rectum tumor, neoadjuvant chemotherapy

[V-063]**Robotic resection of recurrent colorectal cancer metastasis to the seminal vesicle**

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Objective: Robotic surgery is one of the most advanced surgical techniques in which modern medicine meets technology. The robotic system precisely replicates the surgeon's hand movements, eliminates tremor, and provides superior maneuverability in confined spaces. In this video presentation, we will demonstrate the robotic resection performed due to luxation of the seminal vesicle in a 38-year-old male patient who had previously undergone surgery for colon cancer.

Material and Methods: Robotic surgery was chosen as the surgical approach, and the recorded operative video was subsequently processed using professional editing software and prepared for presentation.

Results: Following the surgery, negative surgical margins were achieved, and no mortality or morbidity was observed. The patient remains under postoperative follow-up.

Conclusion: Compared to conventional open surgery and laparoscopic (minimally invasive) surgery, robotic surgery offers several advantages, including three-dimensional high-definition visualization, an enhanced field of view, and improved instrument dexterity. As a result, operations can be performed through smaller incisions, blood loss may be reduced, and patients generally experience a more comfortable and faster recovery process. Performing the procedure using the robotic approach provided a significant advantage to the surgeon in the pelvis, a technically challenging anatomical region, and enabled the achievement of negative surgical margins.

Keywords: Robotic surgery, recurrent metastatic colon cancer, minimally invasive surgery

[V-064]**Robotic surgery in left colon cancer: The evolution of the minimally invasive era**

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Objective: Advances in minimally invasive surgery have increasingly promoted the use of robotic systems in colon cancer surgery. Robotic surgery offers technological advantages such as three-dimensional high-definition imaging, tremor filtration, and wristed instruments, which are designed to overcome the technical limitations of laparoscopy. These features allow for more precise dissection and better adherence to oncological surgical principles in left colon cancer surgery.

Material and Methods: Left colon anatomy involves technically challenging steps such as mobilization of the splenic flexure and dissection of the inferior mesenteric vessels. Robotic systems enhance maneuverability in deep and narrow anatomical spaces, facilitating dissection along proper mesocolic planes. This contributes particularly to safer high vascular ligation and lymph node dissection.

Results: In the current literature, oncological outcomes of robotic left colon resections have been compared with those of open and laparoscopic surgery. No significant differences have been reported between laparoscopic and robotic surgery in terms of adequacy of resection margins or the number of lymph nodes retrieved. Despite these advantages, longer operative times and higher costs remain the main limitations associated with this approach.

Conclusion: Robotic surgery stands out as a safe and effective minimally invasive option in the treatment of left colon cancer. In this context, the aim of this video, which presents a patient operated on with a robotic approach for left colon cancer, is to demonstrate the anatomical structures and anatomical dissections involved in left colon surgery.

Keywords: Robotic surgery, colon cancer, colectomy, lymph node dissection

[V-065]**Robotic low anterior resection and pelvic nerve preservation**

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Objective: Total mesocolic excision is considered the gold standard in rectal cancer. Preserving the hypogastric nerves and pelvic plexuses within the narrow pelvic anatomy improves postoperative functional outcomes. This video presentation describes a case in which pelvic nerves were identified using the Da Vinci Xi robotic surgical system.

Material and Methods: A 76-year-old male patient diagnosed with upper rectal adenocarcinoma and who had completed neonatal and juvenile treatment was scheduled for robotic low anterior resection. A medial-to-lateral approach was preferred during the operation. As the mesorectal dissection progressed, the bilateral hypogastric nerves and plexuses were visualized and preserved in the pelvic lateral walls.

Results: The operation was successfully completed using nerve-sparing principles. The articulation capability of the robotic arms also helped preserve the integrity of the neurovascular structures. The operation lasted 200 minutes. The patient was discharged on the 5th day after the operation. No urinary dysfunction was observed during the patient's stay in the ward.

Conclusion: Robotic surgery has high potential for identifying and preserving important functional structures due to its articulation ability in the narrow pelvic space. Clear visualization and precise dissection of pelvic autonomic nerves also minimize postoperative functional morbidity.

Keywords: Nerve-sparing surgery, rectum cancer, robotic surgery

[V-066]**Postoperative functional outcomes of transanal transection and single-stapled anastomosis technique after low anterior resection in rectal cancer**

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Objective: Anal stenosis (stricture) and functional disorders (incontinence, obstructive defecation) observed after low anterior resection (LAR), one of the sphincter-preserving methods in rectal cancer surgery, are significant factors affecting patients' quality of life. The aim of this study is to evaluate early postoperative anal stenosis and functional outcomes in five patients who underwent LAR using the transanal transection and single-stapled (TTSS) anastomosis technique for rectal cancer at our clinic.

Material and Methods: In this study, the data of five patients who underwent the LAR + TTSS procedure with a diagnosis of rectal cancer were retrospectively reviewed. Patients were evaluated in terms of postoperative anal stricture severity (none, mild, moderate, severe), obstructive defecation score (Altomare-ODS), St. Mark's (Vaizey) incontinence score, and LAR syndrome (LARS) score. Patients with a functioning protective ileostomy were excluded from functional scoring and were analyzed only for the presence of stricture.

Results: In the postoperative evaluation of the five patients included in the study; anal stricture: no anal stricture "none" was detected in 80% (n=4) of the patients, while "moderate" stricture was observed in 20% (n=1). Ileostomy status: protective ileostomies were present in two patients (40%), whereas three patients (60%) were without a stoma. Functional outcomes (n=3): In the functional assessment of the three patients without a stoma; obstructive defecation: a "low score" (<10) was identified in two patients, and a "moderate score" (10-15) was found in one patient (mean score: 9.3). Incontinence: St. Mark's (Vaizey) scores were recorded as 12, 8, and 13, respectively. LARS distribution: minor LARS was detected in one patient, and "major LARS" was identified in two patients.

Conclusion: Based on the preliminary results of our limited case series, it was observed that postoperative anal stricture rates in patients undergoing the TTSS technique were within acceptable levels. Regarding functional outcomes, obstructive defecation symptoms in patients without a stoma were found to be at mild-to-moderate levels; however, monitoring of incontinence scores and LARS remains of clinical significance. Larger patient cohorts and long-term follow-up are necessary to further clarify the functional outcomes of this technique.

Keywords: Rectal cancer, TTSS

[V-068]**Recurrent rectal prolapse, rectocele, and cystocele: Laparoscopic mesh rectopexy with sigmoid colectomy**Fahri Yetişir¹, Mete Yarkin Yetişir²¹Clinic of General Surgery, Acıbadem Bayındır Söğütözü Hospital, Ankara²Başkent University Faculty of Medicine, Ankara

Objective: In this case presentation, we aimed to evaluate the role of the anatomic characteristics of the sigmoid colon in the treatment of our patient with recurrent rectal prolapse and rectocele causing obstructed defecation, and to assess the contribution of sigmoid colon resection to surgical success in recurrent prolapse cases.

Material and Methods: A 43-year-old female patient presented with the main complaints of difficulty in defecation, the need for manual assistance during defecation, and a protrusion from the bowel approximately the size of an orange during defecation. She also reported frequent urination and urinary incontinence. She stated that her symptoms started after a traffic accident. Investigations performed due to these complaints led to the diagnoses of rectal prolapse, rectocele, and cystocele. With these diagnoses, approximately one year earlier, the patient had undergone a laparoscopic anterior mesh rectopexy. However, from the third postoperative month onward, her symptoms increased again and she was re-evaluated. Clinical assessment and imaging studies revealed recurrent rectal prolapse and an advanced rectocele. Based on these findings, surgical intervention was planned for the recurrent prolapse.

Results: During the operation, the sigmoid colon was found to be redundant and folded onto itself in a "W-shaped" configuration. Considering that this condition may have contributed to the recurrence of prolapse, rectopexy was performed together with sigmoid colon resection. During the surgical procedure, the bowel was positioned appropriately in its anatomical location, and to prevent recurrence of the prolapse, the rectum was fixed to the sacral promontory using mesh material. In the postoperative period, the patient remained clinically stable, and a marked decrease in her previous complaints was noted. At the sixth-month postoperative follow-up, her symptoms had significantly improved; no rectal prolapse was observed, and normal defecation function was documented.

Conclusion: This case highlights the importance of the structural characteristics of the sigmoid colon in recurrent rectal prolapse. Rectopexy combined with sigmoid colon resection may be an effective approach in the treatment of prolapse. However, in such complex cases, appropriate patient selection and correct application of surgical techniques are critical to increasing success rates.

Keywords: Rectal prolapse, rectopexy

[V-069]**Inguinal hernia repair with single-port total extraperitoneal (STEP) approach: Our experience**

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Objective: Laparoscopic total extraperitoneal (TEP) approach is a widely used minimally invasive method in inguinal hernia surgery. In recent years, with the development of single-incision laparoscopic surgical techniques, single-port total extraperitoneal (STEP) applications have come to the forefront; however, this technique is applied in a limited number of centers, and there are a limited number of reports in the literature, particularly from our country. This video presentation aims to present the surgical stages and technical details of inguinal hernia repair performed using the STEP technique.

Material and Methods: A 46-year-old male patient diagnosed with unilateral (right) indirect inguinal hernia was prepared under general anesthesia in the supine, 30-degree, Trendelenburg position. Following injection of a local anesthetic (bupivacaine) at the incision site, a 2.5 cm infraumbilical incision was made to access the anterior fascia of the rectus muscle. A 2 cm incision was then made to cut the anterior fascia. The rectus muscle was then pulled laterally. A single-port GelPOINT® mini advanced access platform (Applied Medical, USA) was inserted, and a partial extraperitoneal space was created through blunt dissection via the port. Three trocars were used through the single-port. CO₂ was insufflated into the created space at a pressure of 12 mmHg. Sufficient extraperitoneal space was obtained through blunt dissection. Dissection was performed according to standard TEP surgery principles. A 16*12 cm, right anatomical, 3D, propylene mesh was placed in the preperitoneal space. The implanted mesh was securely fixed to the preperitoneal space at three points using an absorbable fixation system.

Results: The operation was completed without complications. There was no need for intraoperative conversion or additional ports. The operation time was recorded as 35 minutes. No early postoperative complications were observed. The patient was mobilized early and discharged without problems on the first postoperative day. A single-incision was observed to offer advantages in terms of both cosmetic results and postoperative pain.

Conclusion: The STEP approach is a safe and feasible alternative method in selected patients undergoing inguinal hernia surgery. Using a single-incision can reduce potential complications associated with additional ports and offer cosmetic advantages. Sharing the surgical stages of the technique via video presentation is expected to contribute to the learning process of this method.

Keywords: Laparoscopic inguinal hernia repair, minimally invasive surgery, single-incision surgery, single-port total extraperitoneal approach, STEP

[V-070]

Incarcerated Amyand's hernia: Preoperative diagnosis and surgical approach

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Objective: Amyand's hernia is a rare condition defined as the presence of the vermiform appendix within the inguinal hernia sac. Although generally diagnosed intraoperatively, preoperative diagnosis is currently possible with advanced imaging modalities. The aim of this video presentation is to present a case who applied with a painful swelling in the right groin, was diagnosed preoperatively by computed tomography (CT), and was treated via a laparoscopic approach.

Material and Methods: The diagnostic, treatment, and surgical processes of a 69-year-old male patient who presented to our clinic with a complaint of painful swelling in the right groin were recorded. The patient's demographic data, physical examination findings, laboratory parameters, and radiological images were evaluated, and the surgical procedure was prepared in a video presentation format.

Results: A 69-year-old male patient presented with a 4-day history of painful swelling in the right groin. Physical examination of the patient, who had a history of left inguinal hernia repair, revealed a non-reducible incarcerated inguinal hernia on the right side. Laboratory results showed a WBC of $6.18 \times 10^3/\mu\text{L}$ (normal) and a CRP of 65 mg/L (high). Due to the discrepancy between clinical and laboratory findings, an abdominal CT was performed, which revealed the vermiform appendix within the hernia sac in the right inguinal canal (Amyand's hernia). During laparoscopic exploration, the presence of the appendix and mesoappendix in the right inguinal canal was confirmed, and they were reduced into the abdominal cavity. The mesoappendix was dissected, and an appendectomy was performed by applying a homolock clip to the base. The surgical site was irrigated, and a JP drain was placed. Due to the risk of infection, no repair was performed on the inguinal ring (hernia defect), and the procedure was terminated. The patient had an uneventful postoperative course and was discharged on the first postoperative day.

Conclusion: Although Amyand's hernia is rare, it should be considered in the differential diagnosis of incarcerated hernias. In inflammatory cases presenting with high CRP levels, as in this case, the laparoscopic approach is a safe option as it allows for both the exploration of the entire abdomen and the atraumatic reduction of the appendix from the hernia sac.

Keywords: Amyand's hernia, incarcerated inguinal hernia, laparoscopic appendectomy

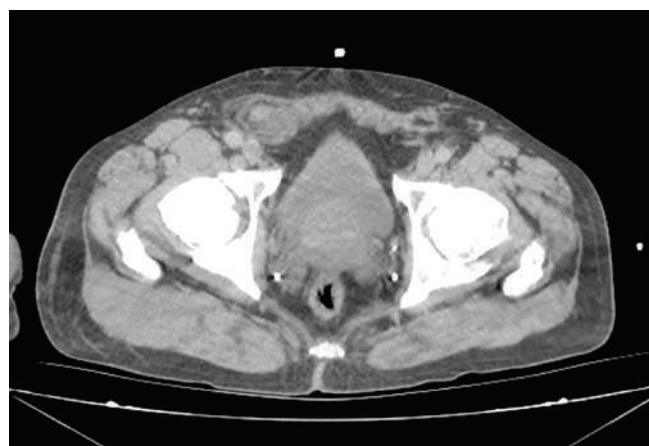


Figure 1. Preoperative computed tomography view of incarcerated Amyand's hernia.

[V-071]

Spleen-preserving laparoscopic distal pancreatectomy and simultaneous endoscopy-assisted laparoscopic gastric wedge resection: Minimally invasive surgery for synchronous gastric and pancreatic neuroendocrine tumors

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Objective: The presence of synchronous lesions in gastroenteropancreatic neuroendocrine tumors (GEP-NETs) is rare but carries significant importance for surgical planning. In this video report, we aimed to present the technique of spleen-preserving laparoscopic distal pancreatectomy combined with simultaneous gastric wedge resection in a case with synchronous NETs located in the stomach and pancreatic tail.

Material and Methods: A 58-year-old female patient with a history of hypothyroidism and diabetes mellitus presented to our clinic. Following an upper respiratory tract infection, she experienced a sensation of obstruction in the throat. Endoscopic examination revealed a gastric mass, prompting further evaluation. Dynamic pancreatic computed tomography (CT), endoscopic ultrasonography, Ga-68 DOTATE PET-CT, and endoscopic biopsy were performed. After a multidisciplinary evaluation, the patient was scheduled for a spleen-preserving laparoscopic distal pancreatectomy combined with simultaneous gastric wedge resection.

Results: The procedure was successfully completed entirely via a laparoscopic approach, with preservation of the spleen. No major intraoperative complications were encountered. Postoperatively, the patient remained hemodynamically stable, and early oral intake and ambulation were initiated without incident.

Conclusion: Spleen-preserving laparoscopic distal pancreatectomy represents a safe and effective minimally invasive approach for small pancreatic tail NETs, offering the added benefit of preserving immune function. In the presence of a synchronous gastric neuroendocrine tumor, combined laparoscopic resection constitutes a feasible surgical option. This video presentation demonstrates the key steps of the surgical technique along with practical procedural details.

Keywords: Minimally invasive surgery, endoscopy-assisted, synchronous neuroendocrine tumor

[V-072]**Robotic intersphincteric low anterior resection and coloanal anastomosis technique**

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Objective: Sphincter-preserving surgical techniques in distal rectal cancer are essential for maintaining quality of life without compromising oncological safety. Intersphincteric resection represents an alternative to abdominoperineal resection in very low rectal tumors. Robotic surgery facilitates these complex procedures by providing enhanced visualization and superior maneuverability within the confined pelvic space. In this study, we aimed to present the technique of robotic intersphincteric low anterior resection with coloanal anastomosis performed in a patient with distal rectal cancer.

Material and Methods: A patient with a T2N0 distal rectal tumor located 1 cm proximal to the dentate line, showing near-complete regression after neoadjuvant chemoradiotherapy, underwent robotic intersphincteric low anterior resection with diverting ileostomy. Following standard robotic surgical principles, ligation of the inferior mesenteric vessels, splenic flexure mobilization, total mesorectal excision, and intersphincteric dissection were performed. The rectum was transected transanally at the level of the dentate line, followed by hand-sewn coloanal anastomosis. A diverting ileostomy was created in the right upper quadrant.

Results: The operation was completed without intraoperative complications. Final pathological examination revealed T2N0M0 disease with negative surgical margins.

Conclusion: Robotic intersphincteric low anterior resection with coloanal anastomosis is a safe and feasible sphincter-preserving option in selected patients with distal rectal cancer. The technical advantages of robotic surgery contribute significantly to precise dissection in the narrow pelvis while maintaining oncological principles.

Keywords: Intersphincteric resection, rectal cancer, robotic surgery

[V-073]**An incisionless approach in robotic colorectal surgery: Transanal specimen extraction**

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Objective: This video presentation aims to demonstrate the management of an intraoperative rectal injury that occurred during robotic low anterior resection in a patient with mid-to-low rectal cancer, while preserving minimally invasive surgical principles.

Material and Methods: A patient diagnosed with rectal adenocarcinoma located just above the Houston valve and staged as cT2N0M0 was discussed in a multidisciplinary tumor board and scheduled for surgical treatment. Robotic low anterior resection was performed in the Lloyd-Davies position following the principles of total mesorectal excision. During distal dissection at the level of the levator muscles, an iatrogenic rectal injury occurred. As distal transection with a stapler was considered unsafe, an alternative approach was adopted. The rectum was transected distal to the tumor, and the proximal rectal stump was closed. The specimen was extracted transanally, and an anvil was secured extracorporeally. An end-to-end colorectal anastomosis was then created using a circular stapler.

Results: The integrity of the anastomosis was confirmed using air and fluid leak tests. The procedure was completed with a protective loop ileostomy. No additional abdominal incision was required. The postoperative course was uneventful. Final pathology revealed T2N0M0 disease, and the patient was followed without adjuvant therapy. The loop ileostomy was closed at the third postoperative month.

Conclusion: Intraoperative complications during robotic rectal surgery can be safely managed with appropriate surgical strategies while maintaining minimally invasive principles. Transanal specimen extraction and circular stapled anastomosis represent an effective alternative approach in selected cases without the need for additional abdominal incisions.

Keywords: Robotic rectal surgery, anastomotic technique, transanal specimen extraction

[V-074]

**Video-based education with surgical-specimen correlation:
Step-by-step laparoscopic splenectomy**Mert Ercan¹, Barış Eker¹, Murat Güner², Erdinç Kamer²¹Department of General Surgery, University of Health Sciences Türkiye, İzmir City Hospital, İzmir²Department of General Surgery, University of Health Sciences Türkiye, İzmir Faculty of Medicine, İzmir

Objective: Laparoscopic surgery, by providing magnified images and a high-resolution visual field, enables clearer visualization of surgical anatomy and allows step-by-step observation of surgical procedures. With these features, laparoscopic approaches offer a more instructive environment for surgical education compared to open surgery. Laparoscopic splenectomy, however, is among the procedures with a long learning curve due to anatomical variations and the complex structure of the splenic ligaments. Accurate identification of intraoperative anatomical structures and the development of three-dimensional perception are of great importance in surgical education. Real-time specimen correlation stands out as an innovative educational method that can support this process by enabling simultaneous comparison of live surgical images with resected tissues.

Material and Methods: In this educational study, a structured training material was created based on a case in which step-by-step laparoscopic splenectomy was performed using standard port placement in the right lateral decubitus position. A total of 38 surgical residents were included and divided into two groups according to their duration of residency: ≤ 2 years ($n=20$) and >2 years ($n=18$). Splenic ligaments (gastrosplenic, splenorenal, splenocolic, splenophrenic, and pancreatosplenic) were identified on the surgical specimen, and a hybrid visual teaching method was employed by providing animation-assisted demonstration of the ligaments and dissection planes on specimen photographs synchronized with the operative video footage (Figure 1). The anatomical recognition levels of the surgical residents regarding the splenic ligaments were analyzed using a structured, 0-10 point evaluation form administered before and after the training. Total performance scores were calculated as percentages. Pre-training and post-training comparisons were performed using paired t-tests, while intergroup comparisons were conducted using independent t-tests.

Results: Before the training, the total anatomical recognition success was $52.0 \pm 10.8\%$ in the ≤ 2 -year group and $64.2 \pm 9.1\%$ in the >2 -year group (Table 2), with a significant difference between the groups ($p < 0.001$). After the training, the total success rate increased to $82.0 \pm 9.6\%$ among all participants (Table 3), and the intergroup difference was no longer observed ($p = 0.219$). When pre-training and post-training change scores were evaluated, the increase in total success was more pronounced in the ≤ 2 -year group compared to the >2 -year group ($29.0 \pm 11.2\%$ vs. $18.8 \pm 8.9\%$; $p = 0.003$). The most prominent improvements were observed in the identification of the gastrosplenic, splenorenal, and splenophrenic ligaments (Table 4). In the evaluation of the training method, three-dimensional anatomical perception and understanding of surgical dissection planes were rated significantly higher (Table 5) in the ≤ 2 -year group ($p = 0.006$, and $p = 0.041$, respectively).

Conclusion: Video-based laparoscopic splenectomy training supported by real-time surgical-specimen correlation significantly improves the

anatomical recognition of splenic ligaments. This method appears to be particularly effective in enhancing anatomical perception and shortening the learning curve in surgical residents with ≤ 2 years of experience. Integrating video-specimen correlation-based training approaches into the education of surgical residents for other laparoscopic procedures may further enhance the effectiveness of surgical training.

Keywords: Laparoscopic splenectomy, video-based surgical education, surgical-specimen correlation, surgical resident education

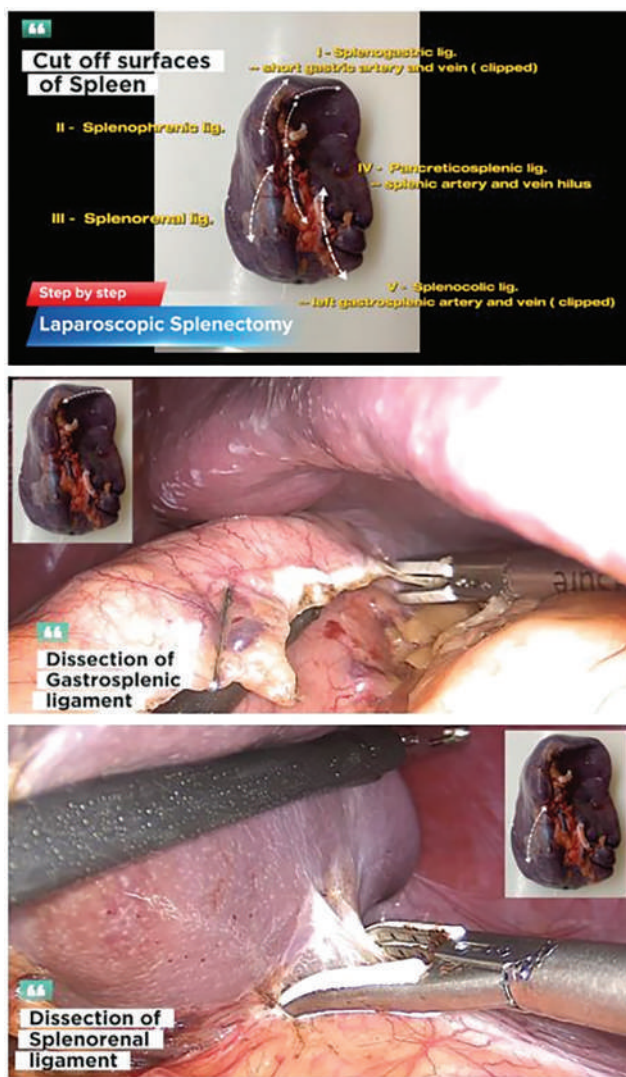


Figure 1. Hybrid educational visualization showing splenic ligament anatomy on the specimen and corresponding intraoperative dissection during laparoscopic splenectomy.

Table 2. Anatomical recognition scores-pre-training

Variable (0-10)	Total	≤2 years	>2 years	p-value
Gastrosplenic ligament	5.1±2.1	4.3±1.9	6.0±1.9	0.008
Splenorenal ligament	5.0±2.3	4.1±2.0	6.1±2.1	0.004
Splenocolic ligament	6.0±1.8	5.4±1.7	6.6±1.7	0.031
Splenophrenic ligament	5.3±2.2	4.6±2.1	6.0±2.1	0.048
Pancreaticosplenic ligament	5.6±2.0	5.2±2.1	6.0±1.9	0.214
Total performance (%)	57.8±11.9	52.0±10.8	64.2±9.1	<0.001

Table 3. Anatomical recognition scores-post-training

Variable (0-10)	Total	≤2 years	>2 years	p-value
Gastrosplenic ligament	8.7±1.5	8.5±1.6	8.9±1.3	0.412
Splenorenal ligament	8.6±1.6	8.4±1.7	8.8±1.4	0.356
Splenocolic ligament	8.1±1.9	8.0±2.0	8.3±1.8	0.598
Splenophrenic ligament	8.4±1.4	8.3±1.5	8.6±1.2	0.477
Pancreaticosplenic ligament	7.8±1.8	7.6±1.9	8.1±1.6	0.332
Total performance (%)	82.0±9.6	81.0±10.4	84.0±8.1	0.219

Table 4. Pre- and post-training change scores (Δ)

Variable (Δ point)	Total	≤2 years	>2 years	p-value
Gastrosplenic ligament	3.6±2.4	4.2±2.5	2.9±2.1	0.041
Splenorenal ligament	3.6±2.6	4.3±2.6	2.8±2.3	0.032
Splenocolic ligament	2.1±2.3	2.6±2.4	1.6±2.0	0.118
Splenophrenic ligament	3.1±2.5	3.7±2.6	2.4±2.2	0.047
Pancreaticosplenic ligament	2.2±2.4	2.4±2.6	2.0±2.1	0.592
Total performance (Δ, %)	24.2±	29.0±	18.8±8.9	0.003

Table 5. Evaluation of the training method (0-10)

Evaluation	Total	≤2 years	>2 years	p-value
Üç boyutlu anatomik algı	8.9±1.10	9.3±0.7	8.5±1.1	0.006
Cerrahi diseksiyon hatlarını anlama	9.0±0.9	9.2±0.8	8.7±1.0	0.041
Diğer laparoskopik girişimlere uygulanabilirlik	8.7±1.1	8.9±1.2	8.5±1.0	0.231

*: Veriler ortalama ± standart sapma olarak sunulmuştur. Gruplar arası karşılaştırmalar independent t-testi ile yapılmıştır.

**: Değerlendirmeler, 0-10 arası sayısal derecelendirme ölçek kullanılarak yapılmıştır.

[V-075]**Pilot application of EPSiT in the office setting**Ahmet Ali Aktaş, Abdullah Boğa, Özgen Işık*Department of General Surgery, Acıbadem Mehmet Ali Aydınlar University Atakent Hospital, Istanbul*

Objective: Endoscopic pilonidal sinus treatment (EPSiT) was introduced approximately a decade ago and has rapidly gained acceptance in clinical practice. Traditionally, the procedure is performed using the Meinero fistuloscope, an 8-degree angled instrument measuring 3.2×4.8 mm in diameter and 18 cm in length, connected to a videoendoscopy unit. The fundamental rationale of EPSiT is the identification of the sinus anatomy under direct visualization, complete removal of hair and debris, and effective ablation. Beyond the advantages of direct vision, the ability to perform the procedure under local anesthesia, avoidance of a large surgical incision, same-day discharge, low risk of major complications, and recurrence rates comparable to other techniques have contributed to its clinical value. The concept of this study arose from the hypothesis that a fiber operoscopy, originally designed for office-based procedures such as hysteroscopy or cystoscopy, could be applied to EPSiT with the same rationale while offering additional practical benefits.

Material and Methods: The fiber operoscopy used is a self-contained device powered by a disposable battery, equipped with an integrated LCD screen and handle. It has a 4.2 mm diameter, a working length of 310 mm, and a central 5.5 Fr working channel. A miniature camera and cold light source are located at its tip, and two separate ports allow infusion and drainage. Unlike the classical fistuloscope, it functions independently without requiring an external unit, while images can be simultaneously transmitted to a standard monitor or recorded.

Results: The procedure begins with the patient in the prone position, the buttocks separated by adhesive bands, followed by local anesthesia. The external openings of the pilonidal sinus are enlarged using a 4 mm punch biopsy blade, and the diagnostic phase proceeds as in classical EPSiT. Isotonic saline (0.9% NaCl) is infused through the scope to explore the sinus cavity, secondary tracts, and any abscesses. In the operative phase, hair and debris are removed with forceps introduced through the working channel. Additional sinus openings are similarly explored, irrigated, and cleaned. Tracts are curetted with a brush and ablated using a ball-tip cautery. Final inspection ensures complete clearance and adequate ablation before termination of the procedure.

Conclusion: This pilot application suggests potential advantages over conventional EPSiT. The absence of operating room requirements, ease of use, and high-resolution imaging support the feasibility of EPSiT as an office-based procedure. Furthermore, integration with classical microsinusotomy may enhance tract clearance and improve overall efficacy. Further studies are warranted to evaluate these potential benefits.

Keywords: Pilonidal disease, EPSiT, office procedures

[V-076]**Surgical repair of Grade 3c and 4 obstetric anal sphincter injuries**Ahmet Anıl Sahar¹, Abdullah Boğa², Ahmet Ali Aktaş², Özgen Işık¹¹*Department of General Surgery, Acıbadem Mehmet Ali Aydınlar University Faculty of Medicine, Istanbul*²*Department of General Surgery, Acıbadem Mehmet Ali Aydınlar University Atakent Hospital, Istanbul*

Objective: Obstetric anal sphincter injuries (OASIS) are a frightening complication of vaginal delivery. According to the Sultan classification, Grade 3c and 4 injuries involve sphincter involvement. When early intervention and appropriate anatomical repair are not performed, these injuries are associated with long-term anal incontinence. The purpose of this video presentation is to demonstrate the systematic and layered anatomical repair technique used in grade 3c and grade 4 OASIS through two case studies.

Material and Methods: In two patients consulted after vaginal delivery, clinical and digital rectal examinations revealed grade 3c injury involving the sphincter complex in one case and grade 4 injury involving the sphincter complex along with the rectal mucosa in the other case. The patients were taken to the operating room under emergency conditions and underwent surgery.

Results: Patients were placed in the lithotomy position to allow perineal exploration. In the patient with a grade 4 injury, the rectal mucosa and wall were identified, followed by identification of the external and internal anal sphincter muscle fibers. Dissection and exposure of the sphincter ends, repair with overlapping sphincteroplasty, perineal body reconstruction, and repair of the perineal muscles and vagina were performed. After checking with a rectal touch and air test, the subcutaneous tissue and skin were closed according to the appropriate plan, and the repair was completed. In the stage 3c patient, the steps mentioned above were performed exactly as described, except for rectal repair. No postoperative complications developed, and the patients were discharged on the second day. No continence problems were observed in the patients followed up at 3 months.

Conclusion: In grade 3c and 4 OASIS, layered repair performed early on, under operating room conditions and in accordance with anatomical principles, is the fundamental approach for preserving anal continence. The video presented offers an applicable and instructive surgical approach for these rare but severe OASIS cases.

Keywords: Obstetric anal sphincter injury, sphincteroplasty, Sultan classification

[V-077]**Robotic right hemicolectomy**Ali Sapmaz, Serhan Yılmaz, Canbert Çelik, Yasin Orhan Erkuş, Şükrü Melih Bayazıtli*University of Health Sciences Türkiye, University of Health Sciences Türkiye, University of Health Sciences Türkiye, University of Health Sciences Türkiye, University of Health Sciences Türkiye, Ankara Bilkent City Hospital, Ankara*

Keywords: Colon cancer, robotic surgery, right hemicolectomy

[V-078]**Ex situ liver with inferior vena cava resection and autotransplantation for hepatic alveolar echinococcosis infiltrating the vena cava**

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Objective: Alveolar echinococcosis is a rare, parasitic disease that behaves locally similar to a malignant tumor. Due to its infiltrative nature, it may invade major vascular and biliary structures, resulting in technically challenging or conventionally unresectable disease. In advanced cases, advanced hepatobiliary and liver transplantation techniques may be required for cases involving hilar vascular and biliary structures, inferior vena cava (IVC), hepatic vein confluence. In these scenarios *ex situ* liver resection and autotransplantation provide an alternative for achieving curative resection in selected patients.

Material and Methods: Here we present a case to demonstrate the feasibility and surgical strategy of *ex situ* liver resection and autotransplantation in an otherwise unresectable case of advanced hepatic alveolar echinococcosis. Alveolar echinococcosis infiltrating the vena cava, hepatic vein confluence.

Results: A 63-year-old male with chronic hepatitis B presented with abdominal pain aggravated by the Valsalva maneuver. Imaging revealed a cystic-calcific infiltrative lesion involving segments IV, VII, and VIII of the liver, causing obliteration of the right and middle hepatic veins and significant narrowing of the retrohepatic IVC and left hepatic vein, resulting in atrophy in the right lobe and hypertrophy and congestion in the left lobe of the liver. The adjacent diaphragm was also invaded. Total hepatectomy, retrohepatic IVC resection, and partial diaphragmatic resection were performed. A dacron interposition graft was used for vena cava reconstruction, followed by portocaval shunt reconstruction. After backtable resection, quilt venoplasty was performed using autologous vein patch for intraparenchymal left hepatic vein. Liver graft was implanted on IVC interposition graft. Portal vein, hepatic artery, and duct-to-duct bile anastomosis was made. The diaphragm

was reconstructed using a prosthetic mesh. The postoperative course was uneventful, and the patient was discharged on postoperative day seven.

Conclusion: *Ex situ* liver resection and autotransplantation is a safe and feasible surgical option that can provide curative treatment in selected patients with advanced alveolar echinococcosis deemed conventionally unresectable, when performed in experienced centers.

Keywords: Alveolar echinococcosis, autotransplantation, *ex situ* liver resection

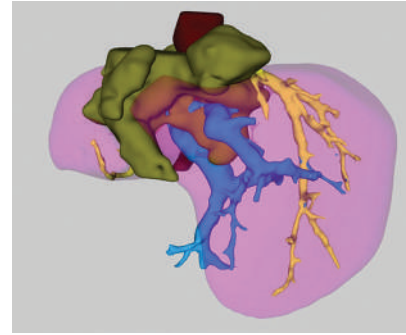


Figure 1.

[V-079]

A foreign body migrating to the hepatoduodenal area following silent duodenal perforation mimicking malignancy: A laparoscopic approach

Mert Şahin Öztürk, Halil Aydoğmuş, Mehmet Zafer Sabuncuoğlu

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Objective: Most gastrointestinal foreign bodies pass spontaneously without causing complications. However, long, thin, and sharp objects such as toothpicks carry a high risk of perforation and may rarely lead to serious intra-abdominal complications. Due to its retroperitoneal location and close anatomical relationship with adjacent organs, duodenal perforations may occur without free intraperitoneal contamination, resulting in silent clinical courses accompanied by localized inflammation and migration. In such cases, pseudotumoral masses mimicking malignancy may develop and lead to misleading findings on advanced imaging modalities. In this study, we present a rare case of a foreign body migrating to the hepatoduodenal area following silent duodenal perforation and discuss the diagnostic and therapeutic role of laparoscopic surgery.

Material and Methods: A 67-year-old female patient with a history of intermittent right upper quadrant pain for several years was evaluated. Ultrasonography, magnetic resonance imaging, and PET-CT revealed a hypermetabolic mass lesion adjacent to the inferomedial segment of the left hepatic lobe and the duodenum, raising suspicion of malignancy. Due to increased FDG uptake on PET-CT, cholangiocarcinoma was considered among the primary differential diagnoses. After interventional radiology suggested the possibility of a foreign body, laparoscopic surgical exploration was planned for diagnostic and therapeutic purposes.

Results: Laparoscopic exploration revealed dense inflammatory adhesions between the duodenum and the liver. Careful sharp and blunt dissection exposed a foreign body migrating from the duodenum into the hepatoduodenal area. The foreign body was identified as a toothpick and was completely removed. A leak test using patent blue dye revealed no evidence of duodenal leakage. The procedure was completed without complications, and the patient had an uneventful postoperative course.

Conclusion: Duodenal foreign bodies may rarely cause silent perforation and migration, leading to pseudotumoral lesions that mimic malignancy on imaging studies. Foreign body migration should be considered in the differential diagnosis of unexplained hepatoduodenal masses with malignant features. Consistent with the literature, laparoscopic surgery provides a safe and effective minimally invasive approach, offering both accurate diagnosis and definitive treatment in such cases.

Keywords: Foreign body, duodenum, laparoscopy



Figure 1. FDG PET image of the tumor.



Figure 2. Extracted foreign body (toothpick).

A toothpick identified during laparoscopic exploration, migrating from the duodenum to the hepatoduodenal area, and completely removed.

[V-081]**Median arcuate ligament syndrome (MALS): A case report and literature review using a laparoscopic decompression approach**

Erkan Karacan, Halim Kale, Ömer Faik Ersoy

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Objective: Median arcuate ligament syndrome (MALS) is a rare vascular syndrome resulting from extrinsic compression of the celiac artery by the median arcuate ligament at the diaphragmatic hiatus. Typical clinical findings include postprandial epigastric pain, weight loss, nausea, and gastrointestinal complaints. Diagnosis is usually based on imaging methods such as CTA (CT angiography) and duplex ultrasonography, and diagnosis is often delayed. This video report aims to present the surgical steps of the laparoscopic median arcuate ligament decompression technique performed in a patient diagnosed with MALS and to review the current literature.

Material and Methods: In the presented case, the patient, who was followed up with prolonged postprandial pain and weight loss, was diagnosed with MALS after detailed radiological evaluation. Using a laparoscopic approach, the gastrohepatic ligament was opened to expose the celiac trunk; the median arcuate ligament and perivascular nerve fibers were dissected, completely eliminating the extrinsic compression on the celiac artery.

Results: No complications developed during laparoscopic decompression, and the patient showed rapid postoperative recovery. In the postoperative period, the patient's complaints significantly decreased, and a control CT angiogram revealed a marked reduction in the external compression on the celiac artery. The patient was discharged without complications.

Conclusion: The clinical and radiological improvement findings are consistent with the results of laparoscopic MALS surgery reported in the literature. Current studies show that the laparoscopic approach provides low morbidity, rapid recovery, and high symptom control rates. This case supports that laparoscopic median arcuate ligament decompression is a safe and effective treatment option with appropriate patient selection.

Keywords: Median arcuate ligament syndrome, laparoscopic decompression, celiac artery compression

[V-082]**Transanal transection single-stapled (TTSS) anastomosis in rectal cancer: Video presentation and evidence-based evaluation of the laparoscopic approach**

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Objective: Ensuring a safe distal margin and reducing the risk of anastomotic leakage are key determinants of surgical success in distal rectal cancer. The aim of this video report is to present the laparoscopic transanal transection single-stapled (TTSS) anastomosis technique performed in a patient with rectal cancer located 2 cm proximal to the anal canal who underwent surgery after total neoadjuvant therapy (TNT), and to evaluate the advantages of this method over conventional very low anterior resection and manually performed coloanal anastomoses in light of the literature.

Material and Methods: Laparoscopic total mesorectal excision was performed in a patient with a tumor lesion 2 cm proximal to the anal canal who had completed the TNT protocol. The distal rectum was transected in a controlled manner via the transanal route, and a TTSS anastomosis was created using a single stapler line. Anastomotic integrity was assessed intraoperatively, and the surgical steps were presented on video.

Results: The surgical procedure was completed without complications. Creating an anastomosis using a single stapler line with the TTSS technique eliminated the risk of ischemic areas and leaks associated with multiple stapler lines seen in classic ultra-low anterior resection. No intraoperative leaks were observed in the anastomosis line. Compared to manually performed coloanal anastomoses, the TTSS technique provided advantages in terms of shorter operation time, less pelvic dissection, a more homogeneous anastomosis line, and preservation of sphincter function. The patient had an uneventful postoperative course, with no anastomotic leakage or major morbidity observed.

Conclusion: The TTSS coloanal anastomosis technique in ultra-low rectal cancer surgery is a rational approach that aims to create a more homogeneous anastomosis line by eliminating staple line intersections. The TTSS technique applied with laparoscopic TME, presented in this video poster, is considered a safe alternative in terms of technical feasibility and early clinical outcomes. Consistent with the current literature, the TTSS approach has a noteworthy potential to reduce the risk of anastomotic leakage; however, prospective and randomized studies with high-level evidence, including long-term oncological and functional outcomes, are needed to demonstrate the true superiority of this method over the standard double-stapled technique.

Keywords: Rectal cancer, transanal transection single-stapled (TTSS), anastomosis laparoscopic, total mesorectal excision (TME)

[V-083]

Endoscopic resection in gastric gastrointestinal stromal tumors-video presentationOnur Can Yenen¹, Yiğit Doğanay Atalay², Efe Özkan¹, Fevzi Cengiz¹¹*İzmir Katip Çelebi University, Atatürk Training and Research Hospital, İzmir*²*Akçadağ Şehit Gökhan Aslan State Hospital, Malatya*

Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract and may arise at various locations, most frequently in the stomach. With the widespread use of endoscopy and endoscopic ultrasonography (EUS), an increasing number of gastric GISTs are detected at an early stage, allowing complete resection. Laparoscopic surgery is considered the standard treatment for gastric GISTs smaller than 5 cm. Compared with laparoscopic surgery, endoscopic resection has been shown to provide similar surgical success and postoperative complication rates, while offering advantages such as reduced intraoperative blood loss, shorter operative time, and shorter hospital stay. Therefore, endoscopic resection has been accepted as an alternative treatment option for gastric GISTs originating from the muscularis propria.

Material and Methods: A 44-year-old female patient underwent endoscopy due to dyspeptic complaints, which revealed a lesion measuring approximately 1.5 cm located on the greater curvature at the corpus–antrum junction. Abdominal CT demonstrated an intraluminal mass of approximately 2 cm at the same location without evidence of invasion. No additional intra-abdominal pathology was detected. The patient underwent endoscopic submucosal resection. Histopathological examination was consistent with GIST, with a tumor size of 3 cm, mitotic count of 3/50 HPF, and no necrosis or atypia.

Results: GISTs are the most common mesenchymal neoplasms arising from the muscularis propria of the stomach and are malignant in approximately 10-30% of cases. According to NCCN guidelines, all GISTs larger than 2 cm should be resected. For GISTs smaller than 2 cm without high-risk features on EUS, endoscopic surveillance may be considered; however, long-term follow-up difficulties and the risks associated with repeated endoscopy limit this approach.

Conclusion: Endoscopic resection is an effective and safe treatment option for selected patients with gastric GISTs, providing comparable surgical success and complication rates, along with reduced operative time, intraoperative blood loss, and length of hospital stay.

Keywords: Endoscopic resection, gastrointestinal stromal tumor

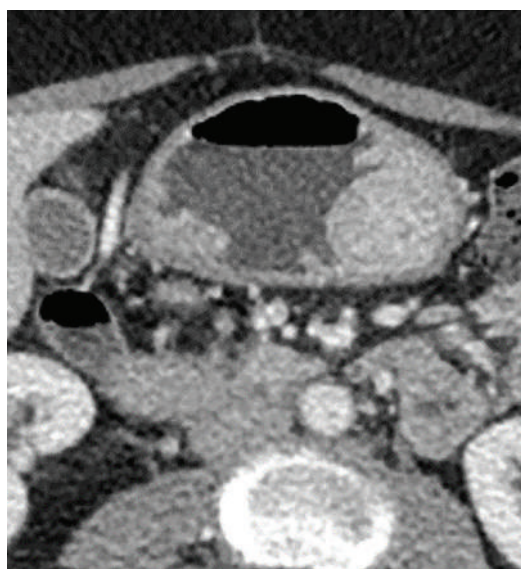


Figure 1. CT image.

[V-084]

A case of celiac-SMA stenosis/chronic mesenteric ischemia treated with aorta-celiac aorta-SMA bypass-case reportHakan Yırgın¹, Yasir Musa Kesgin¹, Anıl Karagöz¹, Ahmet Sürek¹, Murat Çikot¹, Nurettin Şahin¹, Mahmut Said Değerli¹, Sezer Bulut¹, Ferman Özyalvaç¹, Turgut Dönmez¹, Necdet Kılıçaslan², Gökçen Özkan², Cihan Yücel¹¹*Department of General Surgery, University of Health Sciences Türkiye, Bakırköy Dr. Sadi Konuk Training and Research Hospital, İstanbul*²*Department of Cardiovascular Surgery, University of Health Sciences Türkiye, Bakırköy Dr. Sadi Konuk Training and Research Hospital, İstanbul*

Objective: Chronic mesenteric ischemia (CMI) is a rare and underdiagnosed clinical condition associated with postprandial pain due to progressive mesenteric artery narrowing. However, it should not be overlooked that it is more common with age. This condition, explained by inadequate perfusion of the gastrointestinal tract, most often results from atherosclerosis. We aim to share our experience with a case, of which there are very few examples in the literature, of a patient who experienced impaired blood supply and dramatic weight loss following stenosis of the celiac and superior mesenteric arteries, and who underwent surgical treatment with simultaneous bypass surgery between the aorta, celiac, and superior mesenteric arteries.

Material and Methods: A 59-year-old male patient with a medical history of coronary artery disease presented with severe pain or episodes of severe diarrhea approximately half an hour after oral intake for about two years. Abdominal CT angiography revealed occlusion of the celiac artery and superior mesenteric artery, and endovascular intervention was deemed unsuitable. Following examination and investigations, surgical treatment was planned.

Results: The patient underwent surgery under general anesthesia. Following routine abdominal exploration, access to the bursa omentalis was gained through the medial aspect of the lesser curvature, and dissection was continued to expose the hiatal region, celiac trunk, and surrounding areas. The gastroduodenal ligament was opened to expose the pancreas and suprapancreatic area. After identifying the celiac artery and related structures, the superior mesenteric artery was exposed in the inframesocolic space with sharp dissection. Subsequently, a retropancreatic tunnel was created with the help of dissections performed on the supra- and infrapancreatic edges, and prepared to allow the passage of an 8 mm Dacron graft. After aortotomy, end-to-end anastomosis of the aorta and graft, followed by end-to-end graft-SMA anastomosis, and finally end-to-side anastomosis of the celiac graft were performed using 6.0 prolene sutures. Following general control and hemostasis, the patient experienced no significant problems during follow-up in the ward, and oral tolerance was observed. The patient was discharged after recovering.

Conclusion: Simultaneous aorta-celiac aorta-SMA bypass surgery is quite rare in the literature. It may be preferred in patients where interventional approaches have failed or are unsuitable. It can be safely performed in patients with significant symptoms of chronic mesenteric ischemia, allowing them to return to optimal nutritional status, thus leading to positive outcomes in terms of psychology and quality of life.

Keywords: Aorta-coeliac by-pass, chronic mesenteric ischemia, coeliac artery occlusion, mesenteric ischemia

[V-085]**Central pancreatectomy and pancreaticogastrostomy for a cystic tumor located at the pancreatic head/neck: A video-assisted surgical technique presentation**

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Objective: Central pancreatectomy is a parenchyma-sparing surgical option for selected benign and low-grade malignant tumors located at the pancreatic head-neck junction. In contrast to standard pancreaticoduodenectomy, this approach preserves pancreatic endocrine and exocrine function while maintaining gastrointestinal continuity. Various reconstruction techniques have been described following resection. In this report, we present our surgical reconstruction technique using pancreaticogastrostomy after central pancreatectomy, accompanied by an operative video.

Material and Methods: A 67-year-old female presented with epigastric abdominal pain to the General Surgery clinic of Ondokuz Mayıs University Faculty of Medicine. She had no comorbidities or prior surgical history. Body mass index was 27 kg/m². Laboratory parameters, including serum amylase, lipase, and CA 19-9, were within normal limits. Contrast-enhanced computed tomography revealed a 38 × 22 mm multiloculated cystic lesion with a solid component at the pancreatic head-neck junction. Distal to the lesion, irregularity of the main pancreatic duct and focal dilatation up to 5 mm were observed. Magnetic resonance cholangiopancreatography demonstrated no communication between the cystic lesion and the main pancreatic duct. Endoscopic ultrasonography showed normal cyst fluid glucose, carcinoembryonic antigen, and amylase levels. The patient underwent open central pancreatectomy with preservation of the duodenum. Intraoperative frozen-section analysis confirmed negative margins and absence of malignancy. The proximal pancreatic stump was closed with a stapler. Reconstruction was achieved via double-layer duct-to-mucosa pancreaticogastrostomy between the distal pancreatic remnant and the posterior gastric wall. The postoperative course was uneventful, and the patient was discharged on postoperative day five.

Results: Final histopathology confirmed serous cystic neoplasm.

Conclusion: In selected patients with benign or low-grade malignant lesions at the pancreatic head-neck junction, central pancreatectomy combined with pancreaticogastrostomy represents a safe and function-preserving alternative to more extensive resections. This technique maintains gastrointestinal continuity while preserving pancreatic parenchyma and may also be adapted to minimally invasive approaches in experienced centers.

Keywords: Pancreas, central pancreatectomy, pancreaticogastrostomy

[V-086]**New oncoplastic technique in tumors of the lower inner quadrant: Dogan Technique personel procedure**

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Objective: Oncoplastic techniques defined in breast cancer treatment not only expand the indications for breast-conserving surgery but also enable improved cosmetic outcomes. Breast tumors located in the lower inner quadrant, however, pose additional challenges for oncoplastic surgery due to the scarcity of breast tissue and the frequent need for skin resection. In our study, we defined a new oncoplastic technique that prioritizes patient satisfaction for tumors in the lower inner quadrant, aiming to overcome the oncoplastic challenges associated with tumors in this location.

Material and Methods: Preoperatively the medial and inferior borders are determined using the breast fold inferiorly and the sternum medially. A triangular pyramid is designed with its base resting on the breast fold. The intersection of the apex of the triangular pyramid with the superior border of the tumor is one of the key points of the drawing. This defined pyramid is divided into two parts. After division, a parallelogram and a triangle are obtained. The remaining triangular area is where the de-epithelialization process is performed. The remaining parallelogram is designed to be the resection area. Following resection, a glandular flap is created in the superior region. To completely close the resulting defect, the glandular flap is sutured to the superior part of the de-epithelialized area. The incision is sutured along the superior skin line and the inferior border of the de-epithelialized area. This creates a hidden suture line in the inframammary fold.

Results: Multiple techniques are described for lower quadrant tumors. The Dogan Technique can be considered an important alternative in the literature at this point. In the postoperative period, the appropriate incision scar on the fold and the absence of another incision on the remaining breast tissue support cosmetic satisfaction. In tumors of the inner quadrant, the need for centralization in NAK arises in incisions made in the vertical plane, but in incisions made in the horizontal plane, such as our incision, the natural position of NAK is preserved. Not performing surgical procedures on the areola and surrounding area eliminates the risk of ischemia and hypesthesia for NAK. This differs from studies in the literature on this subject.

Conclusion: We applied this technique to five of our patients with lower inner quadrant tumors (2025-2026). We are very satisfied with the oncological and aesthetic results. We anticipate that this technique will be recognized in the literature as a safe, effective, and widely used oncoplastic technique in the future.

Keywords: Oncoplastic, tumors of the lower inner quadrant, Dogan Technique



Figure 1. Preoperative drawing.

Determining resection and de epithelialization areas based on tumor location post-resection appearance.



Figure 2. Resection area and de epithelialization area, free glandular flap.

[V-087]

Laparoscopic creation of permanent access for recurrent benign biliary stricture after open whipple procedure

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Objective: Pancreatoduodenectomy is a highly invasive surgery. Although mortality has decreased to approximately 1%, postoperative complications remain common. While early complications have decreased, late-onset benign hepaticojejunostomy stricture (BHS) remains a significant clinical issue. BHS causes recurrent cholangitis, intrahepatic stones, jaundice, and liver abscess, requiring invasive treatments. Thanks to advanced equipment, endoscopic retrograde cholangiography (ERC) is increasingly successful even in altered anatomies. However, when endoscopic access is impossible, alternative permanent surgical strategies are needed. In this video presentation, we present the laparoscopic creation of a permanent access loop to facilitate ERC in a patient who developed a biliary stricture following an open Whipple procedure.

Material and Methods: A 75-year-old female patient presented with late-onset complications following a Whipple procedure performed for benign reasons in 2005. Her medical history included recurrent cholangitis and liver abscesses since 2007. Throughout this period, multiple percutaneous transhepatic cholangiography interventions, balloon dilatations, and “stent-in-stent” metallic biliary stent placements were performed at external centers. Due to increasing symptoms over the last year, double-balloon enteroscopy was attempted; however, the hepaticojejunostomy (HJ) anastomosis could not be reached due to excessive looping and a long afferent limb. Interventional radiological assessment revealed that the stents were completely occluded and lithogenic. To reduce the morbidity of recurrent invasive procedures and ensure permanent endoscopic access, the laparoscopic creation of a permanent access loop was planned for the patient.

Results: Pneumoperitoneum was established via an open technique for camera trocar insertion; intra-abdominal exploration revealed dense adhesions secondary to the previous Whipple procedure. Following meticulous adhesiolysis, the segment identified as the biliopancreatic limb was mobilized from the transverse colon mesentery and surrounding structures. Intraoperative endoscopy was performed, advancing through the gastroenterostomy site. However, endoscopic air insufflation did not result

in dilatation of the targeted loop, and laparoscopic transillumination of the endoscope light was localized at a different site, allowing for the correct identification of the true afferent limb. After identifying the appropriate segment, a facial defect was created in the right upper quadrant, and the prepared jejunal loop was fixed to this area as a “permanent access loop.” To facilitate future radiological interventions, the loop was marked with a radiopaque band.

Conclusion: Managing benign biliary strictures after an open Whipple is challenging. Laparoscopic creation of a permanent access loop in this altered anatomy is a rarely reported strategy. The created permanent access loop provides a comfortable gateway for percutaneous or endoscopic interventions, offering a minimally invasive and effective solution in stricture management.

Keywords: Access loop, benign biliary stricture, laparoscopic surgery, pancreatoduodenectomy

[V-088]

A breath to acute mesenteric ischemia: Case series of embolectomy of the superior mesenteric artery

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Objective: Acute mesenteric arterial occlusion is a general surgical emergency with high morbidity and mortality, accounting for approximately 65-97% of acute mesenteric ischemia. When caused by embolism, it usually occurs 3 to 10 centimeters distally to the superior mesenteric artery (SMA) origin point.

Material and Methods: In this case series, we evaluated the outcomes of SMA embolectomy performed following explorative laparotomy in 6 patients who presented to the emergency department with acute mesenteric ischemia secondary to SMA embolism.

Results: A total of six patients, 3 males and 3 females, with a mean age of 67.8 years (range: 43-88 years), were included in this study. All patients presented to the emergency department with acute abdominal pain. Computed tomography revealed occlusion at the origin or mid-segment of the superior mesenteric artery (SMA) in all cases. Laboratory evaluation demonstrated a mean white blood cell count of $15.5 \times 10^3/\mu\text{L}$ (range: $9.27 \times 10^3/\mu\text{L}$) and a mean serum lactate level of 2.9 mmol/L (range: 1.49-5.2 mmol/L). All patients were taken to surgery due to acute mesenteric ischemia. Preoperatively, three patients were evaluated by interventional radiology, in two cases no endovascular intervention was deemed appropriate, one patient underwent an endovascular attempt without effective results. All patients subsequently underwent emergency surgical intervention. After assessment of intestinal ischemia and necrosis, the SMA was exposed via a transperitoneal inframesocolic approach. The SMA and jejunal branches were isolated and looped, and SMA embolectomy was performed using a Fogarty catheter after arteriotomy. Intestinal perfusion was then reassessed, necrotic bowel segments were resected, and a planned second-look laparotomy was scheduled to evaluate potential ongoing ischemia. Postoperatively, 2 patients died before a second-look laparotomy could be performed. Two patients required additional bowel resection during the second-look, and at third-look exploration, no pathological findings were observed, allowing for abdominal closure. In the other 2 patients, no pathological findings were

detected at second-look laparotomy, and the abdomen was successfully closed. The mean length of hospital stay was 8.5 days (range: 2-20 days). Two patients died on postoperative day 1. Although ischemia was initially controlled in four patients, two subsequently died due to sudden cardiac arrest on postoperative days 3 and 4, while two patients were discharged in good clinical condition.

Conclusion: Acute mesenteric ischemia, which is associated with high mortality, intraoperative SMA embolectomy may contribute to preservation of intestinal reserve and improved survival outcomes. Therefore, this is an effective treatment option in appropriately selected patients.

Keywords: Embolectomy, mesenteric ischemia, vascular surgery, superior mesenteric artery

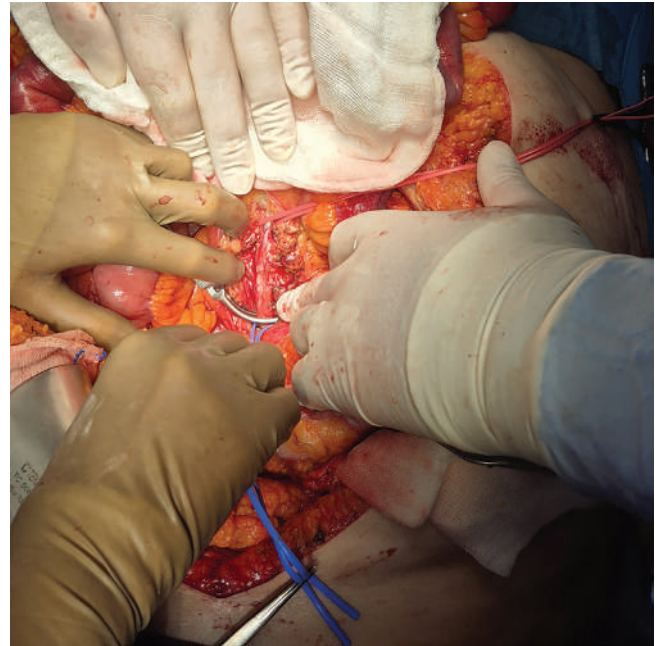


Figure 1. Superior mesenteric artery is exposed and looped.

Table 1. Patient distribution according to the results

	Age-gender	Computed-tomography	Interventional radiology	Operation	Mortality
Patient 1	59-Male	SMA proximally occluded	Ineffective procedure	Abdominal closure after second-look	Sudden cardiac arrest at postoperative day 4
Patient 2	69-Female	SMA occlusion at origin point	No intervention deemed appropriate	Abdominal closure after second-look	Sudden cardiac arrest at postoperative day 3
Patient 3	66-Male	SMA proximally occluded	No intervention deemed appropriate	Abdominal closure after third-look	Discharged
Patient 4	82-Female	SMA occlusion at origin point	-	Second-look couldn't performed	Exitus on postoperative day 1
Patient 5	43-Male	SMA proximally occluded	-	Abdominal closure after third-look	Discharged
Patient 6	88-Female	SMA mid-segment occlusion	-	Second-look couldn't performed	Exitus on postoperative day 1

[V-089]**Laparoscopic and thoracoscopic distal esophagectomy for distal esophageal adenocarcinoma: A video presentation**

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Objective: Minimally invasive approaches have become increasingly common in the surgical management of distal esophageal adenocarcinoma with growing experience. Laparoscopic and thoracoscopic esophagectomy allows preservation of oncologic principles while potentially reducing surgical morbidity in appropriately selected patients. This video presentation demonstrates the technique of laparoscopic and thoracoscopic distal esophagectomy performed for distal esophageal adenocarcinoma.

Material and Methods: A patient with distal esophageal adenocarcinoma who was deemed suitable for surgery after preoperative evaluation underwent a minimally invasive approach. The abdominal phase was performed laparoscopically in the supine position. The omentum majus was dissected along the greater curvature, the gastrohepatic ligament was

opened, and abdominal lymph node dissection was carried out. The left gastric artery was ligated and divided, and a gastric conduit was created. The staple line was reinforced with intracorporeal suturing. During the thoracoscopic phase, the esophagus was mobilized, the azygos vein was clipped and divided, and the gastric conduit was delivered into the thoracic cavity. Esophagogastric anastomosis was performed using a side-to-side technique with an endoscopic linear stapler.

Results: The procedure was completed successfully using a minimally invasive approach. No intraoperative complications were observed. The anastomosis was constructed safely, and the operation was completed under controlled conditions. The video clearly demonstrates the essential steps and technical aspects of the procedure.

Conclusion: Laparoscopic and thoracoscopic distal esophagectomy is a safe and effective surgical option for distal esophageal adenocarcinoma when performed by experienced teams. This video presentation highlights the feasibility of the minimally invasive approach and illustrates key technical steps of the procedure.

Keywords: Distal esophageal adenocarcinoma, esophagogastric anastomosis, laparoscopic esophagectomy, minimally invasive surgery, thoracoscopic esophagectomy