reoperated due to bleeding of cholecystectomy performed simultaneously. Mean length of stay for laparoscopy was 4.2 days. With a follow-up between 2 to 32 months, dysphagia to solid score and thoracic pain score were both 0.8. No patient has presented regurgitation, or dysphagia to liquid. **Conclusions:** We conclude that this procedure is an effective and little agressive treatment, with low morbidity, so we consider it the treatment of choice for this pathology.

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**Stapled Laparoscopic Gastropexy for Paraesophageal Hernia**

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A new method of laparoscopic gastropexy, suitable for correction of symptomatic paraesophageal hernia (PH) in high-risk patients, is described. **Technique:** After reposition of the stomach, a loop suture is percutaneously introduced into the abdomen by using the disposable suturing device (Endo Close, Auto Suture, USA). Insertion should be performed at the cranial level of future gastropey. The end of inserted suture is grasped with a forceps and pulled downward so that a double suture falls along the anterior stomach wall caudally. A laparoscopic hernia stapler (Endo Universal 65, Auto Suture) is introduced and prepositioned to firing. The loop suture is hooked between the protruding stapling legs and is stapled high to the stomach. The suture is further stapled downward resembling a long Nissen anterior gastropey. An empty Endo Close is percutaneously inserted to the caudal border of future gastropey. The end of loop suture is hooked with the open jaw of Endo Close, locked, and pulled through the abdominal wall out. The parietal peritoneum in the area of gastropey is cauterized to improve adhesion. Both ends of loop suture are gently pulled thereby fixing the stomach against the anterior abdominal wall and are knotted over a small supporting device. Two weeks later, both ends of loop suture are cut at the skin level. **Comment:** In high-risk elderly, laparoscopic repair of PH offers advantages, but complete correction is associated with the significant operative time. Minimal invasive approach, consisting of laparoscopic detorsion of the herniated stomach, combined with a long gastropey, offers safe and satisfactory palliation for this particular group of patients. The method is simple, rapid, avoids numerous sutures and knotting, and provides a durable intraabdominal fixation of the stomach.

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**Management of Intrathoracic Stomach with Polypropylene Mesh Prosthesis Reinforced Hiatus Hernia Repair**

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Posterior cruroplasty repair of a large paraesophageal hiatus hernia has a relatively high rate of recurrence due to the inexorable cyclic negative intrathoracic pressure of respiration and positive intraabdominal pressure produced by straining, physical exertion and coughing. To reduce the risk of recurrence after repair of a large hiatus hernia with intrathoracic stomach, we have used posterior cruroplasty reinforced with an onlay polypropylene mesh prosthesis. We reviewed the records of 44 consecutive patients with large hiatus hernia and intrathoracic stomach who had posterior cruroplasty and onlay of polypropylene mesh prosthesis applied adjacent to the crura and diaphragm to repair the hiatal defect. Preoperative symptoms (mean duration 26 months) included pain (33 patients), vomiting (21), dysphagia (19) and anemia (8). The typical patient (28 men and 16 women, mean age 60) had two-thirds or more of the stomach above the diaphragm. Organoaxial gastric volvulus and herniated large or small bowel was present in 10 and 9 patients, respectively.

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**Laparoscopic Nissen-Rossetti Procedure: Clinical Results**

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The aim of the study was a clinical evaluation of the early and late results of the laparoscopic Nissen-Rossetti anti-reflux technique which has the particularity of a minimal dissection without dividing the right and left attachment of the cardia.
A gastrostomy was performed for temporary drainage in 38 patients in addition to the hernia repair; 11 patients who had symptomatic reflux underwent a concomitant Nissen fundoplication. Postoperative complications included pleural effusion (4 patients), atrial dysrhythmia (3), and superficial wound infection (2). Endoscopy and/or barium esophagography was performed during follow-up if a patient had symptoms. Mean follow-up for 43 patients is 52 months. There have been no clinical recurrences. Mesh prosthesis reinforced hiatus hernia repair is effective, appears to have a low recurrence rate, and should be an option in the treatment of a large hiatus hernia with intrathoracic stomach.

502  FP207

Short-Term Comparison of Laparoscopic Antireflux Surgery to Conservative Therapy for Reflux Esophagitis

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The present study evaluates short-term symptomatic and endoscopic outcome in gastroesophageal reflux disease comparing conservative therapy to operative management.

The study comprised 110 consecutive patients referred for reflux syndromes and erosive gastritis confirmed by endoscopy from 1993 to 1994. The patients received conservative management and medication. The esophageal healing was controlled by endoscopy. If conservative management failed to relieve symptoms and esophageal healing, laparoscopic antireflux surgery was performed. The patients were followed-up by clinical examinations and interviews (median 4.75 years). Laparoscopic antireflux surgery was performed in 35 of 110 patients. Results at their follow-up: 32 (91%) had no heartburn, 31 (89%) were free from erosive gastritis, only 1 (3%) was given medication. Corresponding figures in conservative group were 56 (75%), 49 (65%), 16 (21%). In gastroesophageal reflux disease the laparoscopic surgical treatment gave much favourable short-term results compared to those from conservative therapy.

504  FP209

Rare Surgical Approach for Definitive Primary Repair of Esophageal Atresia – A Case Report

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Esophageal atresia is one of the most frequent congenital anomalies of digestive tract. Operative technique for definitive primary repair depends on types of anomalies and risk categories for infants with esophageal atresia. The most frequent type of anomalies is esophageal atresia with distal tracheoesophageal fistula (Vogt type III b or Gross type C). The operation for definitive repair is end-to-end union or end-to-side union as an alternative. This is a case report of an infant with esophageal atresia (type C) that falls into Waterstone’s risk category A. For uniting the esophageal ends was applied rare surgical approach. Anatomical form of anomaly was different than usually: tracheoesophageal fistula had a common wall with the bottom of proximal atretic part of esophagus and the width of fistula was the same as width of the distal part of esophagus.

Operation was done in following manner: tracheoesophageal communication was ligated and transected (fig. 1A), through the opened wall of fistula, the common wall at the bottom of atresia was excised without damage of lateral walls of esophagus (B), nasogastric tube was passed through (C) and operation was finished by simple closure on the opened wall of fistula without standard anastomosis

503  FP208

Appearance of Esophageal Peristalsis after Surgery for Idiopathic Achalasia

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The incidence, cause and clinical significance of peristaltic pressure waves after surgical myotomy in patients suffering from idiopathic achalasia is not yet understood. This study evaluated the modification induced by surgical treatment on esophageal motility patterns in patients with achalasia. Patients and Methods: In a 3.5 years period 6 patients were referred to our hospital diagnosed as having idiopathic achalasia. Dysphagia, regurgitation, variable weight loss and simultaneous non-sequential deglutitive waves and no lower esophageal sphincter relaxation were the currently accepted diagnostic criteria. All patients had been previously treated with pneumatic dilatation. Preoperative investigations concerned clinical assessment, barium swallows, endoscopy, manometry and 24 h pH metry. Peroperatively a Heller cardiomytomy was performed under endoscopical guidance combined with 180° Nissen fundoplication, laparoscopically in all cases but one. Postoperative manometry was performed on a yearly basis. Median follow-up after surgery was 12 months (range 6–40 months). Results: After surgery 5 out of 6 patients had no complaints of dysphagia. No patient had recurrent signs of esophagitis. In all patients manometry showed significantly decreased lower sphincter pressure with partial or complete return of peristasis in 83.4% of the patients. Every patient gained weight after surgery. One patient complained of dysphagia after surgery due to a short stenotic fragment just above the myotomy, despite endoscopical guidance. Pneumatic dilatation was performed here with moderate short-term result. Conclusion: Development of certain degree of peristasis was seen in 80% of our patients treated with surgical myotomy, correlated with excellent clinical outcome. Whether these findings constitute as a real return to peristasis or only an apparent change in motility pattern seems to be controversial.