

Reinforcement by suturing may increase intraoperative total blood loss, require more time and lead to more disease-specific symptoms (when compared to buttressing). Study completion (112 patients) with long term follow up may lead to a greater degree of differences with cost-analysis.

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**ROBOT-ASSISTED VERSUS LAPAROSCOPIC SLEEVE GASTRECTOMY: LEARNING CURVE, PERI-OPERATIVE AND SHORT-TERM OUTCOMES**

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**Background:** Currently, sleeve gastrectomy is most commonly performed laparoscopically. However, robot-assisted approach for sleeve gastrectomy is increasing in number among bariatric surgeons.

**Objectives:** The aim of our study is to compare perioperative outcomes of robot-assisted (RA-LSG) and laparoscopic sleeve gastrectomy (LSG). Setting: Academic Hospital, United States

**Material and Methods:** Between June 2008 and December 2014, 647 patients underwent LSG and RA-LSG at our institution. The first 100 LSG and RA-LSG cases were separated to reflect the influence of learning curve. A retrospective review was performed for 379 LSG and 268 R-LSG patients, noting the outcomes and complications of the procedure.

**Results:** Mean length of hospital stay (LOS) was 1.1±0.3 days (range, 1-2) in initial 100 LSG patients, and 1.3±0.6 days (range, 1-4) in initial 100 RA-LSG patients. Thirty-day readmission rate was 5.0% in LSG patients and 6.0% in RA-LSG patients. No patient in these groups required a reoperation within 30 days, however, one mortality (1.0%) occurred in the RA-LSG group. In the latter groups, mean LOS was 1.2±0.5 days (range, 1-5) in 278 LSG patients, and 1.7±1.8 days (range, 1-21) in 167 RA-LSG patients. Thirty-day readmission rate was 2.2% and 30-day reoperation rate 0.7% in the LSG group. Thirty-day readmission rate was 2.4% and 30-day reoperation rate 1.2% in the RA-LSG group. Overall leak rate was 3.2% (n=9) in the LSG group, and 1.9% (n=5) in the RA-LSG group, and the difference in the leak rate was significant in the RA-LSG group between the initial and latter cases.

**Conclusions:** Our study showed similar 30-day readmission and reoperation rate between LSG and RA-LSG during the learning curve and after the proficiency has been achieved.

**Objective:** Fixed Liver Retraction (FLR) has traditionally been considered mandatory for all foregut surgery. For most procedures (RYGB, Hiatal Hernia repair) operative exposure of the lesser curvature of the stomach and right crus does require fixed retraction. Sleeve gastrectomy (SG) requires visualization of the angle of His and left crus, but not “right sided” structures. We hypothesize that selective use of FLR in SG may minimize complications (pain and narcotic use, liver injury, liver infarction or necrosis), and improve outcomes (length of stay, patient satisfaction and cosmesis) without compromising efficiency and safety (Op time, EWL and EBL) We describe two techniques to preserve uncompromised visualization.

**Method:** We prospectively examined all cases of SG over 3 months (primary SG or as part of DS). Hiatal Hernia repair and revisional surgery cases were excluded. Age, gender, BMI and major Co-morbidities were tracked. Outcomes analyzed include narcotic use and pain scores, liver injury, liver function tests, length of stay, estimated blood loss, Operative time, readmission within 30 days of surgery. We will describe and present video of two operative techniques that allow for complete visualization of Left Crus and Angle of His.

**Results:** A total of 112 patients underwent any type of Sleeve Gastrectomy procedure in the 3 month study period. 14 were excluded for HH, 3 were excluded for revision. 62 had primary Sleeve and 33 had sleeve as part of DS. 61.29% (38/62) of Primary Sleeve patients did not require fixed liver retraction. Liver injury, estimated blood loss, Length of stay, operative time and pain scoring results did not meet statistical significance.

**Conclusion:** Retractor-related liver injuries and post-operative pain are previously described in the literature. Our study shows selective use of Fixed Liver Retraction results in no significant difference in complications or outcomes. This novel technique is simple and safe and provides equivalent possibly superior outcomes.

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**OUTCOME OF SLEEVE GASTRECTOMY IN ELDERLY OBESE PATIENTS**

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**Introduction:** A coincident phenomenon of our age and society is global ageing and obesity’s pandemic. Bariatric surgery represents the therapy of choice in morbidly obese patients due to its safety and clinical efficacy. Consequently the indication for bariatric surgery in elderly obese patients becomes more relevant as it is considered to be less effective and associated with higher morbidity. Long-term data concerning outcome of sleeve gastrectomy in elderly obese patients are still lacking.

**Material and methods:** This study represents a retrospective, single-center analyses of all sleeve gastrectomies performed in patients older than 55 years between 2003-2014. Data such as postoperative outcome of weight parameters and comorbidities, complication rate, length of stay, impact on quality of life (BAROS-Score) and food tolerance score were reviewed.

Table 2. Comparison of LOS, 30-day readmission and reoperation, and leak rate between LSG and RA-LSG patients

	LSG First 100 <sup>a</sup> (n=100)	RA-LSG First 100 <sup>a</sup> (n=100)	P value	LSG after 100 <sup>a</sup> (n=278)	RA-LSG after 100 <sup>a</sup> (n=167)	P value
Mean LOS (days)	1.1±0.3	1.3±0.6	<0.01	1.2±0.5	1.7±1.8	<0.01
Readmission rate (30-day)	5.0% (n=5)	6.0% (n=6)	>0.37	2.2% (n=6)	2.4% (n=4)	>0.88
Reoperation rate (30-day)	0%	0%	N/A	0.7% (n=2)	1.2% (n=2)	>0.60
Identified leak rate	4.0% (n=4)	4.0% (n=4)	>0.99	3.2% (n=5)	1.9% (n=1)	>0.28

<sup>a</sup> Patients were separated to two groups for each approach, as 100 initial cases and latter cases.

LSG : laparoscopic sleeve gastrectomy  
RA-LSG : robot-assisted laparoscopic sleeve gastrectomy  
LOS : length of hospital stay

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