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RIGHT-SIDED APPROACH FOR LEFT MAIN BRONCHIAL SLEEVE RESECTION IN ADENOID CYSTIC CARCINOMA: TECHNICAL NUANCES AND INNOVATION IN AIRWAY MANAGEMENT

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Introduction:
Central airway tumors involving the left main bronchus (LMB) present a formidable surgical challenge due to proximity to the carina, limited exposure, and the need for precise reconstruction. Adenoid cystic carcinoma, though slow-growing, demonstrates submucosal and perineural spread, necessitating complete resection. In resource-limited settings, technical adaptations are critical to achieve oncologic and functional outcomes while avoiding dependence on costly adjuncts such as ECMO or specialized jet ventilation

Material and Method:
We present a 27-year-old male with chronic cough and hemoptysis. Bronchoscopy revealed a nodular lesion involving 50% of the LMB circumference, 1 cm distal to the carina. Histology confirmed adenoid cystic carcinoma. Surgery was performed in the left lateral decubitus position via a right-sided approach, beginning uniportal VATS and later converting to posterolateral thoracotomy for exposure. Dissection included azygos division and complete subcarinal lymphadenectomy. Airway reconstruction was performed using continuous 4-0 delayed absorbable sutures.

Results:
A major intraoperative limitation was the absence of ECMO and jet ventilation. A novel, low-cost strategy of high-flow oxygenation via a 16G IV cannula provided adequate oxygenation and uninterrupted anastomosis. The patient recovered uneventfully, chest drains were removed on day 3, and he was discharged on day 4. Histopathology confirmed negative margins and uninvolved nodes.

Conclusion:
Right-sided approach offers superior access to proximal LMB tumors. Innovative airway management using IV cannula oxygenation represents a safe, resource-optimized alternative in low-resource settings. This strategy emphasizes adaptability, avoids ECMO-associated risks and costs, and ensures curative resection in young patients requiring parenchyma-sparing surgery.

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ROBOTIC RIGHT COLECTOMY IN A ELDERLY PATIENT DUE TO A CECUM ADENOCARCIONOMS

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Introduction:
The global population is aging, and with it, the prevalence of colorectal cancer (CRC) is increasing. Individuals aged ≥80 years represent a unique and growing subset of CRC patients. Minimally invasive surgery (MIS), particularly robotic-assisted colorectal surgery (RACS), has gained attention for its potential benefits in this demographic. RACS provides three-dimensional (3D) vision, wristed instrumentation motion scaling, tremor elimination, and improved ergonomics.

Material and Method:
A 92-year-old female with a medical history of arterial hypertension, dyslipidemia, obesity (BMI 40kg/m2), and pulmonary. She required red blood cell transfusion to maintain hemoglobin levels around 8 g/dL. Colonoscopy revealed a bleeding cecal mass with invasion of the ileocecal valve. Biopsy confirmed adenocarcinoma. Computed tomography showed a cecal tumor approximately 7.8 cm in diameter, without evidence of distant metastasis. A robotic approach was proposed and informed consent obtained.

Results:
Right colectomy was performed with 12 mmHg pneumoperitoneum. Operative time was 60 minutes with 30 mL blood loss. One unit of blood was transfused. No intraoperative complications occurred. Recovery was uneventful and the patient was discharged on postoperative day 11. Pathology revealed a moderate adenocarcinoma of the Cecum 7.8cm in size with free margins. Stage T4aN1c and a total of 25 lymph nodes were removed

Conclusion:
Early results from comparative studies show that RACS is safe and feasible in the elderly and it potentially confers the benefit of lower conversion, earlier return of gut function and shorter length of stay with comparable oncological outcomes. As such, age alone should not be a strict exclusion criterion for RACS.

ISW26-292-03 (0852)

REAL-TIME DYNAMIC IMAGE OVERLAY WITH INDOCYANINE GREEN (ICG) IN LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction:
Indocyanine green (ICG) is a cyanine dye that fluoresces under near-infrared light. Initially applied in ophthalmology, its use has expanded to multiple surgical specialties, including gallbladder and biliary tract surgery. When administered intravenously, ICG enables—depending on the latency period—the identification of vascular and biliary structures within Calot's triangle, allowing real-time dynamic image overlay during surgery. Using optical systems with specific filters, surgeons can visualize vascular structures, anatomical planes in monochromatic mode, and biliary drainage pathways, as well as detect anatomical variations of the biliary tree.

Material and Method:
An illustrative video of a laparoscopic cholecystectomy using ICG for real-time image overlay is presented, demonstrating progressive identification of biliary and vascular structures during dissection.

Results:
ICG-assisted overlay enabled clear visualization of the cystic duct and common bile duct, facilitating Strasberg's critical view of safety and improving dissection precision. Further prospective studies are required to define its role in routine versus selected cases.

Conclusion:
ICG with dynamic overlay optimizes anatomical identification, enhances surgical safety, and may reduce operative times by enabling earlier recognition of critical structures. This technology should be used as an adjunct, not a substitute for conventional methods such as intraoperative transcystic cholangiography, particularly in patients meeting ASGE criteria for suspected choledocholithiasis.

ISW26-292-04 (0772)

WANDERING SPLEEN CAUSING SMALL BOWEL OBSTRUCTION: LAPAROSCOPIC SURGICAL TREATMENT (WITH VIDEO)

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Introduction:
Wandering spleen (WS) is a clinical entity in which the spleen is not located in its normal anatomical site. Few cases have been reported, mainly in women of childbearing age. This condition can be congenital or acquired due to excessive elasticity of the spleen's suspensory ligaments. WS may cause acute complications requiring emergency surgery, especially related to the rotation of its vascular pedicle, leading to chronic or acute ischemia. The aim of the present case is to show a rare complication of WS, small bowel obstruction (SBO), and its management.

Material and Method:
We report the case of a 40-year-old female presenting with abdominal pain, nausea, and vomiting. CT scan showed SBO caused by WS located in the pelvis with an enlarged spleen vascular pedicle (SVP).

Results:
WS may cause chronic or acute complications, mainly linked with enlargement and torsion of SVP, including acute ischemia and spleen necrosis, or compression of the near organs such as small intestine, stomach, pancreas. The diagnosis is based on physical examination, CT scan and blood exams. Generally, the WS's treatment is laparoscopic splenectomy or splenopexy. In case of vital spleen, splenopexy can be performed, in case of not vital spleen, splenectomy should be preferred.

Conclusion:
This case provides an excellent example of SBO related to WS. In the video, the management of this complex situation is shown. In these cases, splenectomy represents a valuable option.

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LAPAROSCOPIC DUODENOJEJUNOSTOMY IN A CASE OF SUPERIOR MESENTERIC ARTERY SYNDROME OR WILKIE'S SYNDROME, WITH VIDEO

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Introduction:
Superior mesenteric artery syndrome (SMAS), also known as Wilkie's syndrome, is a rare but potentially debilitating condition resulting from extrinsic compression of the third portion of the duodenum between the superior mesenteric artery (SMA) and the abdominal aorta (AA). This compression can cause a partial or complete duodenal obstruction, leading to symptoms like early satiety, postprandial abdominal pain, nausea, vomiting, and progressive weight loss. Diagnosis is confirmed by imaging, including CT scan, which reveals a narrowed aorto-mesenteric angle and decreased distance between the SMA and the AA.

Material and Method:
We report the case of a 30-year-old female presenting with a six-month history of progressive postprandial abdominal pain and a 30 kg weight loss. Radiologic evaluation with oral contrast X-ray and CT imaging showed narrowing of the third portion of the duodenum, with an aorto-mesenteric angle (AMA) of 15°. Considering the patient's poor response to conservative nutritional therapy, a laparoscopic latero-lateral duodenojejunostomy was performed.

Results:
The patient remained asymptomatic at one-year follow-up, regained weight, and at the endoscopic evaluation were no evidence of obstruction.

Conclusion:
This case supports the growing evidence that laparoscopic duodenojejunostomy is a safe and effective surgical option for SMAS in patients unresponsive to conservative therapy.

ISW26-292-06 (0167)

BRINGING INVISIBLE TO LIGHT: OUR EXPERIENCE OF ICG IN MINIMALLY INVASIVE THORACIC SURGERIES IN RESOURCE LIMITED SETTINGS

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Introduction:
Indocyanine green (ICG) has gained prominence in thoracic oncology for its safety, affordability, and real-time fluorescence properties. Initially used to assess conduit vascularity, recent advances have expanded its role in delineating complex thoracic anatomy, aiding tumor localization, and minimizing surgical morbidity. We describe four emerging applications of ICG in thoracic surgery: lung nodule visualisation, bronchial visualisation, lung segment and vascular delineation, and thoracic duct identification

Material and Method:
For intraparenchymal nodules, 2.5 mL intravenous ICG (2.5 mg/mL) enabled selective retention in nodules, facilitating minimally invasive metastasectomy. For segmentectomy, intravenous ICG (2.5 mg bolus) delineated intersegmental planes under near-infrared (NIR) imaging, avoiding the limitations of inflation–deflation, especially in emphysematous lungs. Repeated boluses remained well below the maximum recommended dose of 2 mg/kg/day. For tracheobronchial tree visualization, we administered 3 mL nebulized ICG (2.5 mg/mL) pre-intubation via standard nebulizer, achieving 100% accuracy without specialized equipment. For thoracic duct mapping, bilateral inguinal injections(0.5 mL on each side around femoral vessels) of ICG without ultrasound guidance demonstrated a 96% success rate, simplifying a traditionally complex technique.

Results:
Intravenous ICG facilitated precise nodule localization and segmental delineation, with repeated doses safely below limits. Nebulized ICG accurately visualized the tracheobronchial tree without specialized devices. Inguinal ICG injections mapped the thoracic duct with 96% success, avoiding ultrasound guidance. All techniques proved safe, feasible, and reproducible in minimally invasive thoracic surgery.

Conclusion:
Techniques like pre-intubation nebulization and unguided inguinal injections are particularly suited to resource-limited, salvage surgery settings, demonstrating feasibility, safety, and cost-effectiveness