



# VIDEO ABSTRACTS

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## **V1. LAPAROSCOPIC PERCUTANEOUS EXTRAPERITONEAL CLOSURE (LPEC) OF PEDIATRIC INGUINAL HERNIAS**

*J Zequeira, K Diaz*

**Presenter:** Keila Diaz MD

*University of Puerto Rico*

**Introduction:** Pediatric inguinal hernia repairs have been performed for many decades with great results and minimal changes in technique. With the advent of pediatric minimally invasive surgery, new techniques have been developed, with varying degrees of success, in an effort to achieve the same results as with open surgery but with smaller incisions.

**Methods:** The patient is placed in supine position under general endotracheal anesthesia. A trans-umbilical incision is performed and a single 3.5mm trocar inserted into the peritoneal cavity. A 3mm 30 degree angled lens is introduced to visualize the hernia and assess the contralateral side. A 3mm Maryland dissector is then introduced percutaneously through one of the lower quadrants which will be used for assistance during the passage of our high ligation sutures. It will also be used to cauterize the peritoneum at the level of the internal inguinal ring from 10 o'clock to the 4 o'clock position. This promotes scarring once high ligation has been completed. An 18 gauge Tuohy needle is then introduced percutaneously at the level of the internal inguinal ring and passed pre-peritoneally, without manipulating the vas deferens or spermatic vessels, around half of the circumference of the internal inguinal ring. The needle is then used to perforate the peritoneum and a 3-0 prolene suture loop passed into the peritoneal cavity. The needle is then retracted and passed through the other half-circumference of the internal inguinal ring in the same fashion. The 3-0 prolene loop is then used to snare the needle through which an additional 3-0 prolene loop is passed. The original intraperitoneal 3-0 prolene loop snares the new one after needle removal and is used to pull the new 3-0 prolene loop through the other half-circumference of the internal inguinal ring and outside the patient's body. This loop is then used to exchange the 3-0 prolene for a 2-0 or 3-0 vicryl suture which is afterwards cut in half and the hernia sac is double ligated.

**Results:** Thirty-one LPECs have been performed in 24 patients. There has been one recurrence in an 800gram baby with an incarcerated hernia. Parents seem very pleased with the cosmetic results with some of these wounds completely imperceptible. No other complications have been recorded.

**Conclusion:** Our preliminary findings show that LPEC might be safely done in Puerto Rico. Long-term follow up results are still needed.

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## **2. LAPAROSCIC REPAIR OF A GIANT PARAESOPHAGEAL HERNIA**

*RC Pullatt, K Quinn, C Cox*

**Presenter:** Kristen Quinn MD

*Medical University of South Carolina*

**Introduction:** The patient is a 83 y/o Female who presented to the ER with increasing dysphagia, the patient had been worked up earlier and had a known paraesophageal hernia, pt did not tolerate manometry when she was seen in clinic and had an endoscopy which was significant for a giant paraesophageal hernia but no other pathology. Due to the increasing dysphagia the patient was taken to the operating room and the technical details of the repair is demonstrated in the Video. The patient has done well and has no evidence of recurrence and has not represented with any dysphagia.

### **V 3. IRREVERSIBLE ELECTROPORATION OF NON-HEPATIC AND NON-PANCREATIC CANCERS: A SINGLE SITE ASSESSMENT OF FEASIBILITY AND OUTCOMES**

*EL Simmerman, J Chung, CE Jones, EJ Kruse*

**Presenter:** Erika Simmerman DO

*Medical College of Georgia at Augusta University*

**Introduction:** The use of irreversible electroporation (IRE) is a fairly recent innovation in the surgical management of oncologic disease with promising early results. This ablative technique proposes the ability to locally manage solid neoplasms with both definable tissue selectivity and the absence of thermal necrosis and its sequelae. We have incorporated the use of intra-operative IRE in the treatment of primary and metastatic tumors when attempting to achieve local control in close R1 resections. Our study seeks to evaluate this use of IRE in the treatment of non-pancreatic and non-hepatic cancers and to further assess its utility in margin enhancement.

**Methods:** This is a retrospective chart review of a prospective database at a single tertiary institution. Included were patients with pathologically proven cancer whom underwent IRE from November 2013 through May 2016 at the time of surgical resection of primary and/or metastatic tumors for margin enhancement. Primary tumors included colon, retroperitoneal, mesenteric, pelvic and extremity tumors.

**Results:** 17 patients received intraoperative IRE for margin enhancement of non-hepatic and non-pancreatic lesions. Of these patients, 9 (57.9%) had no recurrence, 2 (11.8%) had local recurrence, and 6 (35.3%) experienced distant recurrence. Median followup was 27 months. 2 patients (11.8%) reported nerve palsies/parasthesias possibly attributable to IRE use due to the proximity to our ablative zone and the affected structures, though also known complications of the surgical resection.

**Conclusion:** We report a local recurrence rate of only 11.8% in patients treated with intra-operative IRE and demonstrated no related intra-operative complications. Intra-operative IRE was not associated with unplanned re-interventions or readmissions within the global 30 day post-operative period. As such, we propose that intra-operative IRE may serve as a viable and safe adjunct in the surgical management of non-pancreatic and non-hepatic cancers in attaining clinically R1 resection margins. This contention would benefit from extensive patient follow up and investigation of prospective data.

## **V 4. ROBOT-ASSISTED DISTAL GASTRECTOMY WITH D2 LYMPHADENECTOMY**

*MD Ferguson, JT Watson, JL Deneve*

**Presenter:** Margaret Ferguson MD

*University of Tennessee Medical Center, Memphis*

**Introduction:** Gastric cancer is the fourth leading cancer and third leading cause of cancer death in the world. It has a 5-year survival of 68.1% if localized, 27% if regional spread to lymph nodes, and 35% if distant metastases. It is estimated that there will be 26,240 new cases in 2018 and 10,800 deaths as a result of the disease. Surgery remains the only chance for a cure for suitable patients with local or regional disease in combination with chemotherapy and radiation. Several studies have shown the advantages and limitations of the laparoscopic approach. Robotic-assisted gastrectomy has been shown to have better short-term and comparable oncologic outcomes to the laparoscopic technique.

**METHODS** This case is a 60 year old female who initially presented to the hospital for weight loss, early satiety, gastrointestinal bleeding and dizziness. Her past medical history included hypertension, hyperlipidemia, diabetes, gastroesophageal reflux disease, coronary artery disease, status post stent placement. Family history was significant for gastric cancer in sister. She underwent a colonoscopy and EGD and was found to have 1.5 x 2 cm ulcer at distal gastric body in the area of lesser curvature just above the angularis. Pathology demonstrated gastric adenocarcinoma, signet ring cell type. EUS demonstrated 1.5cm x 2.0cm malignant appearing ulcer. EUS Stage-T1b N0. She underwent a robot-assisted distal gastrectomy, omentectomy, D2 lymphadenectomy and Billroth II gastrojejunostomy.

**RESULTS** The surgical pathology returned 2.5 cm invasive poorly differentiated adenocarcinoma, diffuse type, with focal signet ring cell morphology. The margins were negative. It was negative for lymphovascular invasion or perineural invasion. The lymph node sampled were 7 Perigastric lymph nodes, 4 Lesser omentum and left gastric lymph nodes, 1 Hepatic and portal lymph node, 1 Splenic artery lymph node. Thus it was staged T3N0, stage 2A gastric adenocarcinoma by American Joint Committee on Cancer classification system. The patient was admitted to the floor postoperatively with ERAS protocol for pain management. She was discharged home on post operative day number 5 with no perioperative complications. She has since begun adjuvant systemic chemotherapy with Xeloda/Oxaliplatin.

**CONCLUSIONS** Early stage gastric adenocarcinoma may be appropriately managed with robotic assisted distal gastrectomy and lymph node dissection. Robotic assisted technology allows for excellent visualization, early return of postoperative function, and early initiation of adjuvant therapy.

## **V 5. HELLER MYOTOMY AND DOR FUNDOPLICATION FOR FUNCTIONAL ESOPHAGOGASTRIC JUNCTION OUTFLOW OBSTRUCTION: A VIDEO CASE REPORT**

*TW Mansour, WO Richards*

**Presenter:** Timothy Mansour MD  
*University of South Alabama Medical Center*

**Introduction:** Esophagogastric Junction Outflow Obstruction (EGJOO) is a relatively new diagnosis since the advent of High Resolution Manometry (HRM). Our understanding of treatment for this condition is evolving. Here we present the case of a 69 year old female who presented with a two year history of progressive gastroesophageal reflux symptoms and associated dysphagia. She underwent an extensive workup which was unremarkable until HRM revealed findings consistent with EGJOO. She was offered a laparoscopic Heller myotomy and Dor fundoplication and had excellent results with regard to symptom resolution. In the accompanying video, this case is discussed and technical aspects of the operation are shown in detail.

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## **V 6. ROBOTIC PERINEAL HERNIA REPAIR FOLLOWING ABDOMINOPERINEAL RESECTION**

*RW Farmer, A Cross, J Jordan*

**Presenter:** Russell Farmer MD

*University of Louisville*

**Introduction:** This video is intended to review techniques for minimally invasive repair of a rare, perineal hernia following abdominoperineal resection. This type of hernia can be very limiting for rectal cancer survivors, and a minimally invasive approach is now available to resolve what can be a very technically difficult operation. We will review the basics of the repair, pertinent anatomy, pitfalls to avoid, and technical points.

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## **V 7. ROBOT ASSISTED MEDIAN ARCUATE LIGAMENT RELEASE**

*RC Pullatt, C Cox, K Quinn, G Mercier*

**Presenter:** Caroline Cox MD

*Medical University of South Carolina*

**Introduction:** The patient is a 26 y/o female who had postprandial pain, pain was relieved by leaning forward. Endoscopy, ugi, usg, ct scan were all negative for GI pathology, duplex usg showed elevated velocities in the celiac and CTA showed a narrowing at the origin of the celiac artery. Vascular surgery made a referral to us for a median arcuate ligament release. The patient was examined, studies reviewed and a decision was made to operate. The technical details of the surgery are seen in the video. The patient has done well and is pain free in follow up.

# VIDEO ABSTRACTS CONTINUED

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## **V 8. LAPARO-ENDOSCOPIC SINGLE SITE (LESS) HIATAL HERNIA REPAIR WITH NISSEN FUNDOPLICATION**

*SB Ross, I Sucandy, T Bordeau, DK Craig, AS Rosemurgy*

**Presenter:** Sharona Ross MD

*Florida Hospital Tampa*

**Introduction:** This video demonstrates a Laparo-Endoscopic Single Site (LESS) repair of a large hiatal hernia with Nissen fundoplication in a 42-year old man who presented with GERD, with which he has suffered for over 10 years despite PPI therapy. On EGD, a large hiatal hernia was noted. UGI with a barium laden food bolus documented normal esophageal motility. Bupivacaine was applied at the umbilicus and an 8mm incision was made. A SILSTM port was placed with four trocars, pneumoperitoneum was established, and under laparoscopic guidance, the liver was retracted. The hiatal hernia was reduced from the mediastinum and the dissection began through the gastrocolic omentum toward the right crus. Then, the stomach was rolled to the patient's right and the short gastric vessels were divided. Ultimately, the entire hiatal hernia was reduced into the peritoneal cavity with 8cm of distal esophagus and the hernia sac was divided and removed. Reconstruction of the esophageal hiatus was undertaken using an Endo Stitch™ with V-Loc™ sutures so that the hiatus was snug, but not tight, around the esophagus. The posterior fundus was brought dorsal to the esophagus, and with a large bougie per os into the stomach the anterior fundus (not body of the stomach) was sutured to the esophagus and then the posterior fundus. An intraoperative EGD was undertaken to document that the fundoplication was appropriately constructed at and above the GE junction; a Grade 1 valve was apparent. The posterior fundus was anchored to the esophagus and right crus and the anterior fundus was anchored to the esophagus and left crus. The umbilical defect was closed with a figure-of-8 stitch and a simple single stitch, for reinforcement. The skin was approximated with interrupted absorbable sutures and a sterile dressing was applied. The patient tolerated the operation well with an uneventful postoperative course and was discharged the next morning on a soft diet.

## **V 9. LAPAROSCOPIC LEFT ADRENALECTOMY IN A PATIENT WITH EPISODIC ANXIETY, HYPERTENSION AND A LEFT ADRENAL MASS WITH SURPRISING PATHOLOGY**

*J Zequeira, R De Ayala, L Dorna, M Gomez*

**Presenter:** Rafael De Ayala MD

*University of Puerto Rico*

**Introduction:** This is the case of a 20 year old male patient with episodic anxiety, hypertension and a mildly elevated serum epinephrine level. An abdominal pelvic CT scan revealed the presence of a left adrenal mass. The patient was premedicated for two weeks with an oral alpha blocker. He was not beta-blocked due to the absence of tachycardia. The patient was then taken to the operating room for a laparoscopic left adrenalectomy.

**Methods:** The patient is placed in supine position with a large gel bolster under his left flank. He is then secured to the table with thigh and chest belts. A trans-umbilical incision is performed and a single 5mm trocar inserted into the peritoneal cavity. Two additional 5mm and one 11mm trocars were placed in the epigastrium, right upper, and left upper quadrants. The splenic flexure was mobilized, the lesser sac entered, the stomach suspended with a transabdominal suture and the inferior edge of the pancreatic tail fully mobilized. The retroperitoneum was then entered, the adrenal gland dissected, and the vein divided between endoclips. An exophytic, cyst-like tumor was removed in block with the adrenal gland. Grossly, this tumor did not look like an adrenal medullary neoplasm.

**Results:** The patient was discharged home on post-operative day #3 without the need for narcotic medications and tolerating a regular diet. His blood pressure is normal and he has not suffered from repeated episodes of anxiety. Pathology revealed an intrabdominal bronchogenic cyst which is a very uncommon pathology. MIBG scan done afterwards which showed no suspicious lesions.

**Conclusion:** Intrabdominal bronchogenic cysts are very uncommon. To our knowledge this is the first case presenting as an adrenal mass with episodic anxiety and hypertension.

# VIDEO ABSTRACTS CONTINUED

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## **V 10. ROBOTIC TAPP REPAIR OF MORGAGNI HERNIA WITH MESH**

*R Flores, S Hewlett*

**Presenter:** Robert Flores MD

*Brookwood Baptist Health System*

**Introduction:** The patient is a 37 year old male who had a known Morgagni hernia which was asymptomatic until recently. He had a CT scan which revealed colon and small intestine within the hernia. His presenting symptom was chest pain. After negative cardiac workup, we elected to repair his hernia. We found the robotic TAPP approach to be the best option for the patient. The TAPP approach worked very well. It allows mesh placement while protecting the bowel from direct contact with the mesh. The Xi robot was used. Port placement was at the level of the umbilicus which in retrospect was too low (dissection of the posterior portion of the hernia sac would have been easier with different port positions).

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## **V 11. SLEEVE RESECTION OF COLOSTOMY PROLAPSE**

*MR Arnold, KW Cunningham, PE Fischer, MJ Avery, BW Thomas, AB Christmas, RF Sing*

**Presenter:** Michael Arnold MD

*Atrium Health*

**Introduction:** A 38-year-old male who presented with abdominal pain with nausea and emesis due to a prolapsed colostomy that had worsened over a 3-month period. Previous medical history included active Crohn's disease with peri-anal disease. The patient was maintained on 5mg prednisone daily and was noncompliant with infliximab. Past surgical history was significant for cholecystectomy, multiple peri-anal fistulas, ileo-cecectomy, 3 separate laparotomies for bowel resection and colostomy. A pre-operative colonoscopy demonstrated mildly active Crohn's disease at the ileo-colonic anastomosis. The decision was made to perform a sleeve resection to avoid laparotomy. The patient was taken to the OR, and placed in the supine position. The prolapse was initially elongated. The mucocutaneous junction was then divided circumferentially around the ostomy, taking care not to injure the bowel beneath. After the division, the telescoping was reduced and the redundancy was excised. The fascia was then felt to check for parastomal hernia, and in this case no hernia was identified. Four sutures were then placed to the fascia from the colon, one in each quadrant, tacking the colon to the fascia. The excess colon was then excised by first placing a simple suture at the new mucocutaneous junction in order to tether the bowel to the skin and the bowel was then sutured, circumferentially, to recreate the colostomy. Finally, the last portion of the mesentery to the prolapse was divided and the colostomy was completed. The patient was discharged post-operative day 5 with a delay due to social issues. Sleeve resection of a prolapsed colostomy is appropriate in symptomatic patients who are poor surgical candidates. This decision was made to avoid the morbidity of laparotomy in a patient that likely had significant adhesions and was at high risk of both intraoperative and postoperative complications.

# VIDEO ABSTRACTS CONTINUED

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## **V 12. MINIMALLY INVASIVE MANAGEMENT OF SUBSTERNAL GOITER: A CASE SERIES**

*JY Liu, RK Chihara, ND Saunders, MS Sancheti, FG Fernandez, CJ Weber, J Sharma, SG Patel*

**Presenter:** Jessica Liu MD, MS  
*Emory University*

**Introduction:** Classic management of substernal goiter can require manubriotomy, sternotomy, or thoracotomy, however this contributes to significant pain and morbidity for patients. In this case series, we describe two minimally invasive approaches to managing substernal goiter. We were able to successfully perform a VATS mobilization of a substernal goiter as well as a robot assisted thyroid lobectomy for a substernal goiter. Both thyroid lobes were very large and located substernally and could not have been freed from the inferior attachments from a cervical approach alone. With both cases we were still able to perform intraoperative nerve monitoring by exchanging the endotracheal tube in the VATS case and utilizing a dragonfly electrode with a double lumen endotracheal tube in the robotic assisted case. Our first patient was a 54 yo F with a large substernal goiter. She underwent first a video-assisted thoracoscopic surgery (VATS) to free up the substernal goiter to the level of the thoracic inlet and then had completion of her case through a cervical incision. Our second patient was a 68 yo F with a large medial mediastinum substernal goiter with compressive symptoms. She underwent a robot assisted thyroid lobectomy for substernal goiter without requiring intraoperative repositioning. Intraoperative nerve monitoring was utilized in both cases, and a novel method of pairing a dragonfly electrode with a double lumen endotracheal tube was utilized to account for the needs of an intrathoracic case. Additionally, three additional patients were prepared for our robot assisted technique, however all three cases were able to be completed through a cervical incision alone. To our knowledge, only two other robotic assisted thyroid lobectomies for substernal goiter have been described and both of these required intraoperative repositioning. Two advantages to the robotic approach we described is that no intraoperative patient repositioning is required, and patients are given an opportunity for the goiter to be removed through the cervical incision prior to entering the chest. We conclude that the utilization of minimally invasive surgery in conjunction with a cervical approach is an effective technique for large substernal goiters.

# VIDEO ABSTRACTS CONTINUED

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## **V 13. ROBOTIC ASSISTED LUNG CARCINOID TUMOR RESECTION WITH BRONCHOPLASTY**

*JS Tingen, S Ben-Or, W Bolton*

**Presenter:** Joseph Tingen MD  
*Greenville Health System*

**Introduction:** “Robotic assisted lung carcinoid tumor resection with bronchoplasty” displays a minimally invasive option for proximal endobronchial tumor resection with functional reconstruction. This video discusses a twenty-three year old male Hodgkins lymphoma survivor who is status post chemo-radiation. He presented in follow up with intermittent hemoptysis and workup revealed biopsy proven carcinoid tumor of the left upper lobe bronchus. He was taken for surgical resection. This video displays the technique for a robotic assisted proximal pulmonary tumor resection that has both anatomic and technically challenging aspects. Only recently are case series being published on robotic assisted bronchoplasty as the traditional approach to these tumors is via thoracotomy. There are limited reports of this technique being used for carcinoid tumors.

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## **V 14. ROBOTIC VERTICAL BANDED GASTROPLASTY REVISION TO RETROCOLIC GASTRIC BYPASS WITH HIATAL HERNIA REPAIR**

*AE Martin, D Stefanidis*

**Presenter:** Anna Martin

*Indiana University School of Medicine*

**Introduction:** Gastric Bypass is an effective procedure for long-term weight loss. In this video, we present a robotic revision of failed vertical banded gastroplasty to retrocolic gastric bypass with hiatal hernia repair on a 58-year-old female. The patient was morbidly obese with a BMI of 50 and associated comorbidities. She had undergone an extensive and comprehensive pre-op evaluation and had been found to be an excellent candidate for weight loss surgery. She had a prior VBG with significant weight regain and had a hiatal hernia on pre-op EGD along with band erosion. For her operation 3 robotic arms and an additional 12 mm laparoscopic port were used. Lysis of adhesions was extensive and took 2 hours due to her prior open surgery. A retrocolic 150 cm Roux was created to minimize anastomotic tension. The gastric pouch was divided using endoscopic guidance to avoid leaving devascularized tissue behind; the remnant fundus was removed to make pouch creation easier. The hiatal hernia was repaired posteriorly with a 0 Ethabond suture. The jejunojejunostomy, Peterson's and mesocolic defects were approximated with silk suture. A leak test using EGD was negative. The procedure lasted 5 hours. There were no intraoperative complications, and the patient was discharged home on POD #1. On 3 months follow up, the patient's energy levels had returned to normal, and she had lost 40 pounds from her baseline. Enhanced 3D visualization, platform stability, and improved precision make the use of robotic surgery for complex foregut and bariatric procedures appealing.

## **V 15. ROBOTIC LEFT HEMICOLECTOMY WITH TRANS RECTAL SPECIMEN EXTRACTION: A VIDEO SUBMISSION**

*CM Merritt, KA Climaco, AS Walker*

**Presenter:** Clay Merritt DO

*William Beaumont Army Medical Center*

**Introduction:** Trans Rectal Specimen Extraction (TRSE) is an example of Natural Orifice Specimen Extraction (NOSE). Laparoscopic partial colectomy with TRSE is regularly described in the literature, whereas, descriptions of a robotic technique are nearly absent. We present a video showing our technique for TRSE after robotic left hemicolectomy and discuss the possible role of TRSE in robotic colorectal surgery.

**Methods:** A 46 year old female with a 3 cm non resectable, descending colon, tubulovillous adenoma was consented for robotic left hemicolectomy. We use the da Vinci Xi® platform (Intuitive Surgical, Sunnyvale, CA, USA). Four ports are placed, medial to lateral left colonic dissection with splenic flexure mobilization is performed and the colon is stapled and divided at the proximal margin. The distal margin is divided sharply and an Endoloop® ligature (Ethicon, Somerville, NJ, USA) is used to close the specimen side. The anvil is passed through the rectum, placed into the proximal colon, and secured using an Endoloop. A colonoscope is used for TRSE. An intracorporeal EEA stapled colorectal anastomosis is performed. Colonic blood supply is evaluated using FireFly™. An insufflation leak test is performed.

**Results:** We successfully performed a TRSE of the descending colon using the robotic platform. Pathology showed a benign 3 cm tubulovillous adenoma. No post-operative complications occurred. The patient was discharged home on postoperative day 2.

**Conclusion:** We have shown a feasible technique for TRSE after robotic left hemicolectomy. Current TRSE data is heterogeneous and does not include patients treated with the robotic approach. We believe this technique will be useful in those patients who are morbidly obese by removing the need to place the anvil and extract the specimen through a very thick abdominal wall. This technique may also decrease port site hernia rates as there is no need to extend any robotic port incision for specimen extraction. Current data supporting TRSE for malignant lesions is limited, therefore; we recommend TRSE for presumed benign lesions. This technique should be in any surgeons' armamentarium who performs left sided colon resections.

# VIDEO ABSTRACTS CONTINUED

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## **V 16. UMBILICAL FLAP CLOSURE OF GASTROSCHISIS, DRESSING CHANGES AND RESULTS**

*J Zequeira, K Ruiz, K Echeverria*

**Presenter:** Karla Ruiz MD

*University of Puerto Rico*

**Introduction:** Gastroschisis is a well-known disorder for which treatment has passed through many phases. There continues to be much diversity with regards to the ways pediatric surgeons treat patients with gastroschisis. We present one of our first umbilical flap closures of a gastroschisis defect. We have progressed to perform this closure in a suture-less fashion.

**Methods:** The eviscerated bowel/organs are either reduced into the peritoneal cavity within 6 hours of birth or serially with the help of a spring-loaded silo. The umbilical flap was then sutured to the patient's skin around the abdominal wall defect. The flap was in turn covered with a petrolatum impregnated gauze and a hydrocellular dressing which had the dressing change instructions written on it. The dressing was not changed for the first 5 days post-surgery. Then, it was changed every 3 days, removed in a left to right direction, the area cleaned with sterile saline and covered in the same manner.

**Results:** The patient was discharged about one month post initial intervention. After one year follow up the patient's umbilicus is in the midline and there is a small umbilical hernia associated to it that we expect might resolve on its own prior to five years of age.

**Conclusion:** Umbilical flap repair of gastroschisis associated abdominal wall defect can be safely performed at the bedside without the need of a general anesthetic and with acceptable cosmetic results.