

### Key Steps

- Opening of the gastrohepatic ligament preserving the hepatic branch of the anterior vagus nerve
- Dissection of the phrenoesophageal fat pad off the anterior esophagus
- Take down of the short gastric vessels
- Creation of myotomy
- EGD to confirm adequate myotomy
- Creation of Dor Fundoplication

### Advantages of the Robot

- 3 dimensional views
  - Improved ability to visualize muscle fibers, resulting in improved myotomy
- Increased articulation During myotomy, the ability to have finer movements
  - hand controls are transitioned to 3:1 to allow for finer dissection

### Our Outcomes

- 46 patients reviewed
- Intra-operative perforation rate of 0%, compared to 11.5% laparoscopically

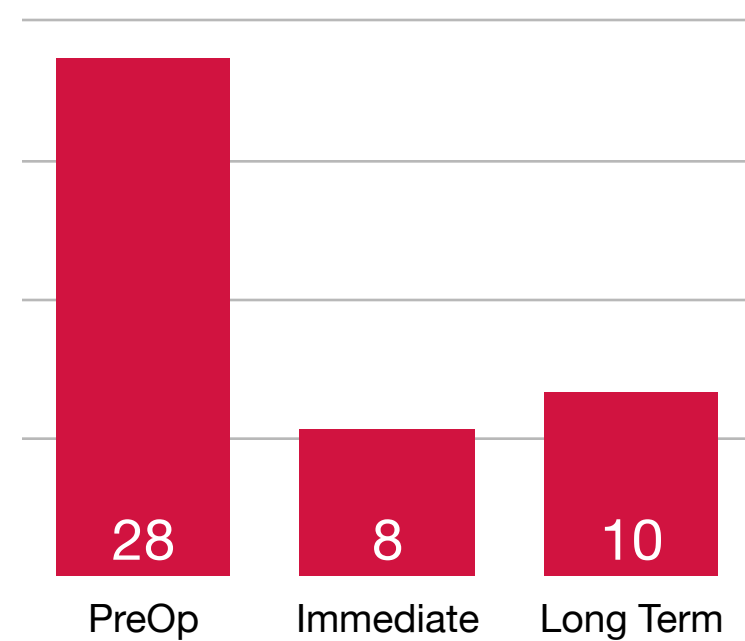
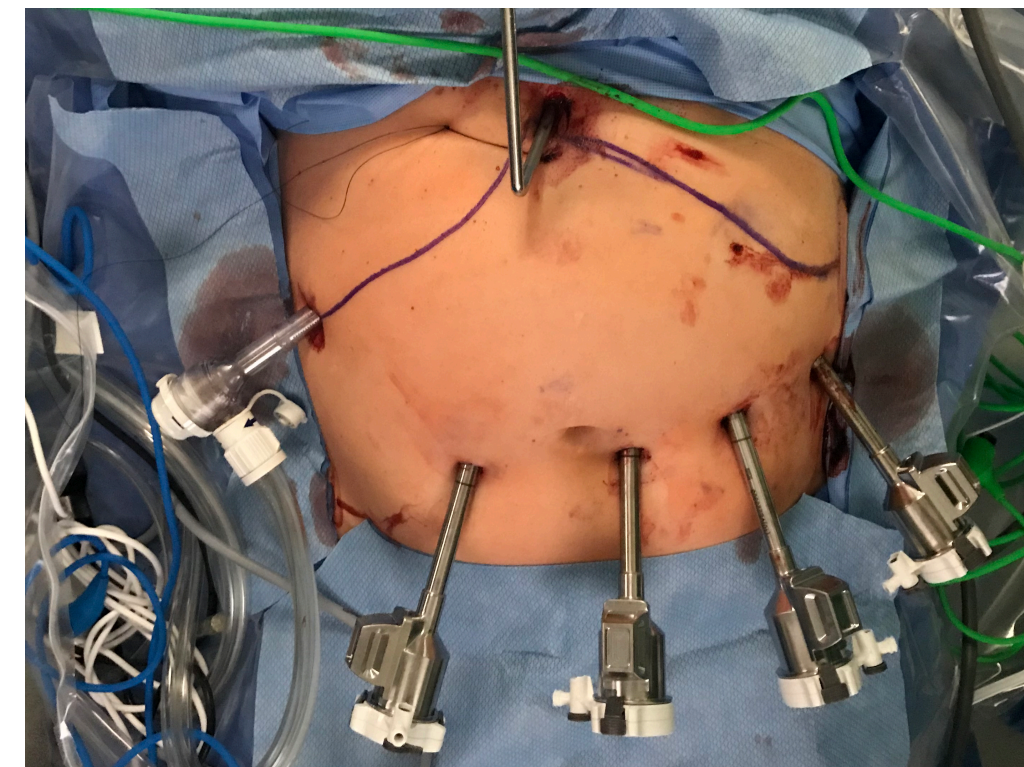
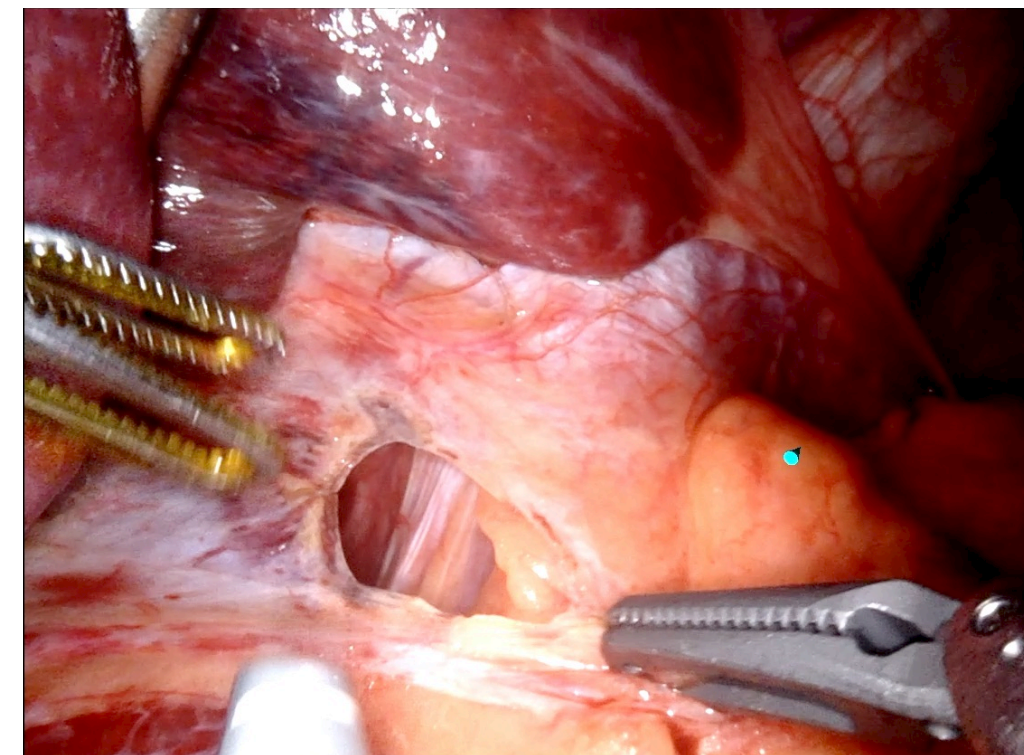


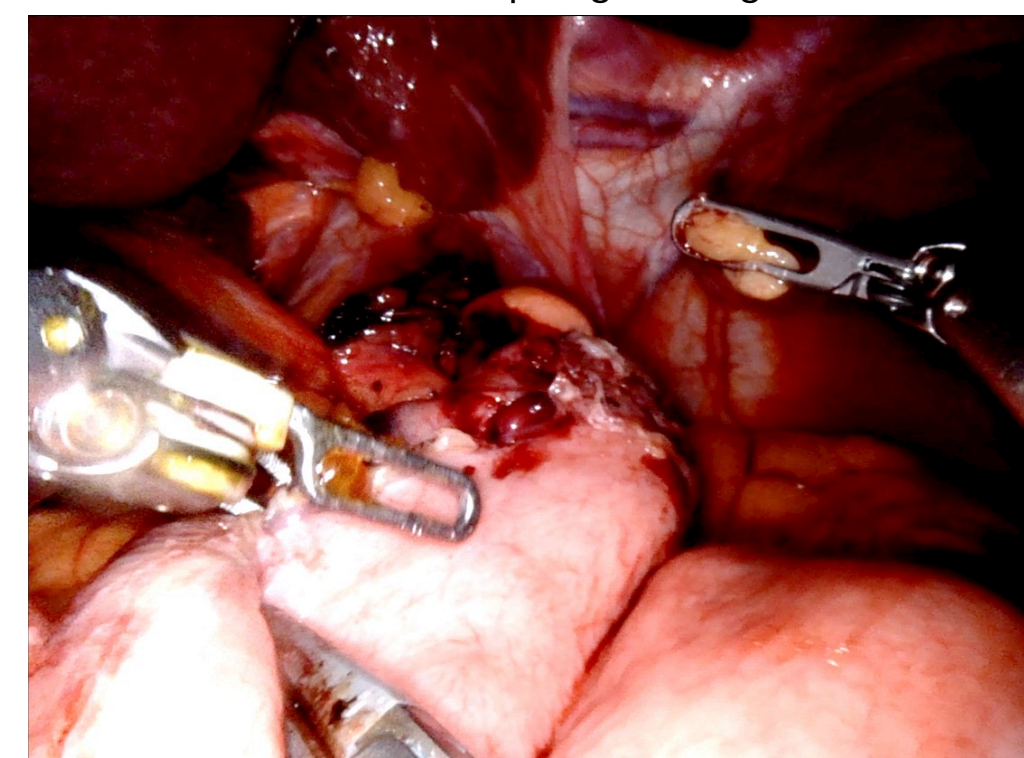
Figure 1: GERD HQRL scores were obtained pre, immediately post and at long term follow up. There has been a significant decrease in scores, indicating good long term outcomes. ( $p < 0.0001$ )



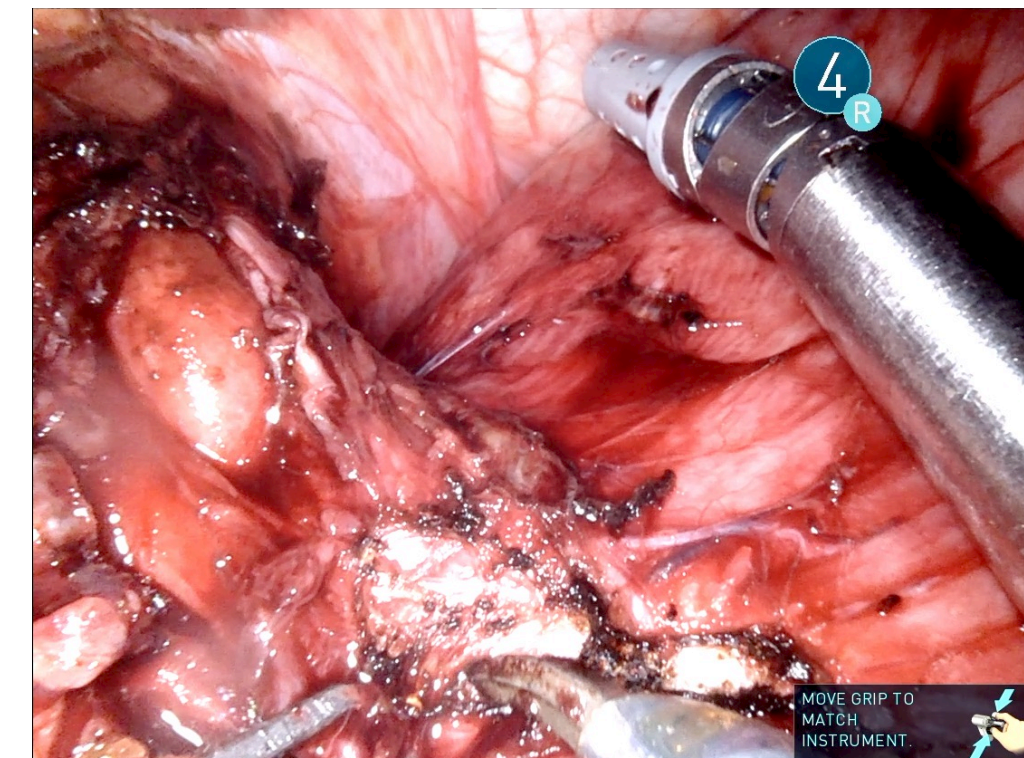
Port Placement



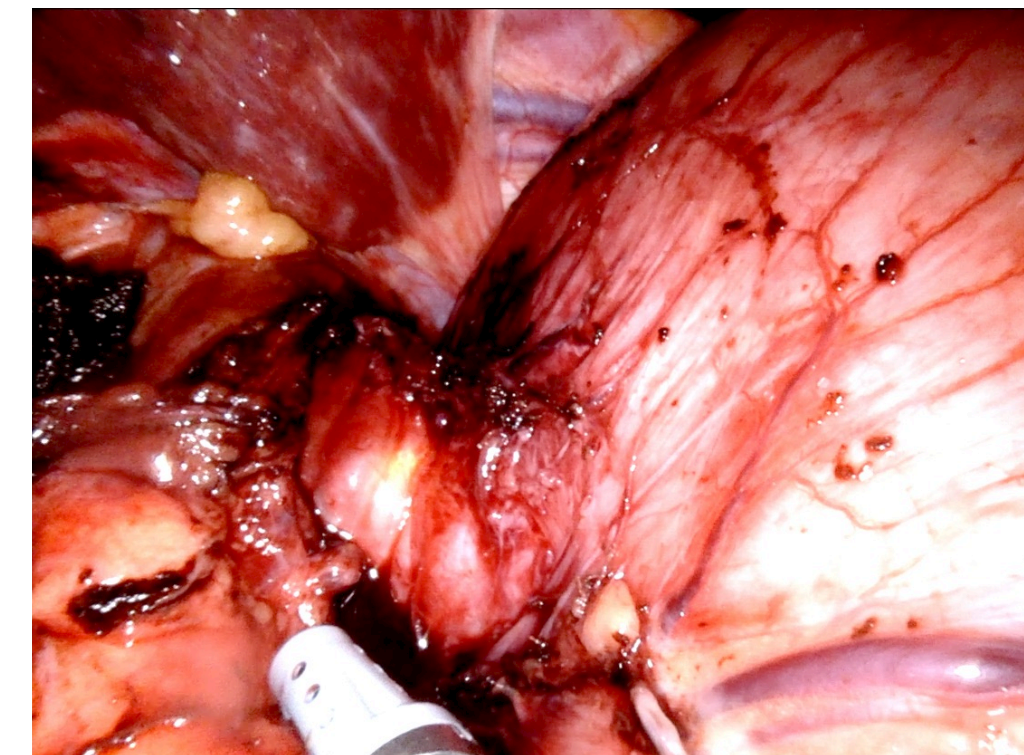
1. Division of the Hepatogastric ligament



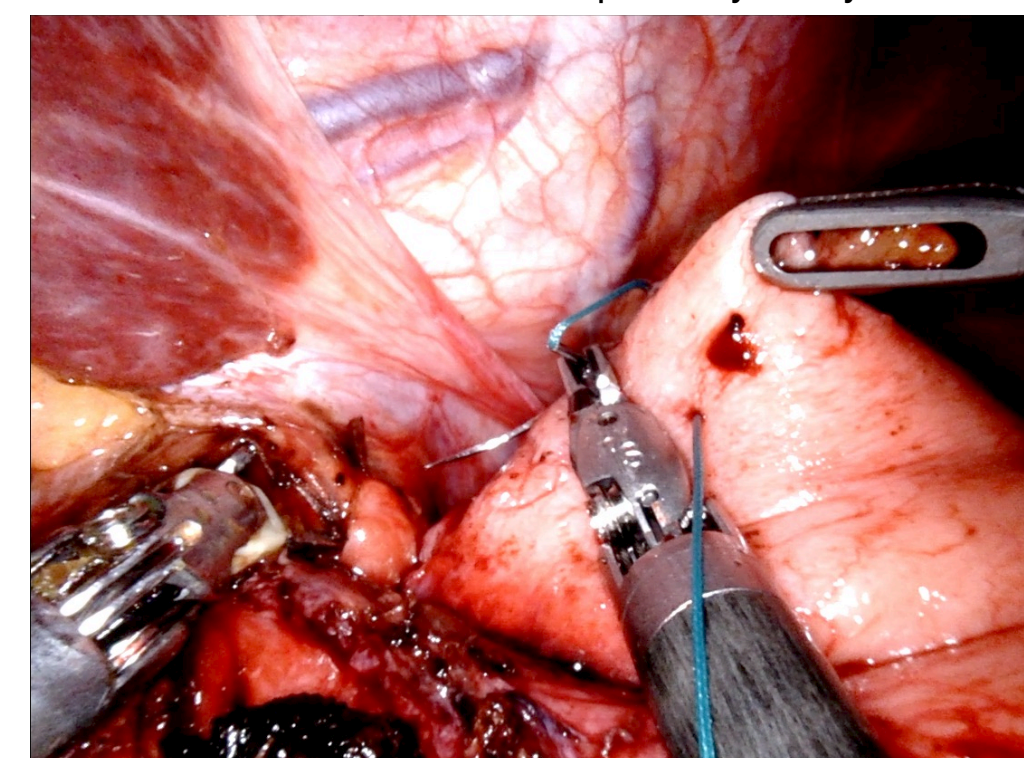
2. Fundus mobilized with short gastrics ligated



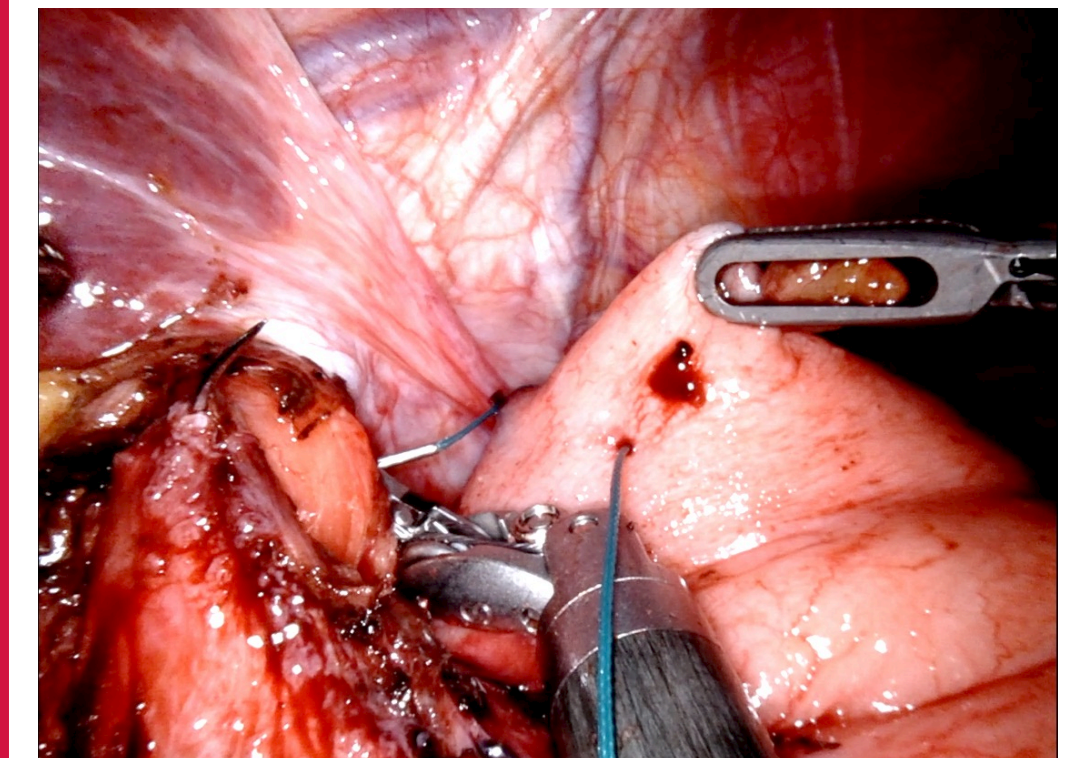
3. Myotomy in progress with mucosa bulging out



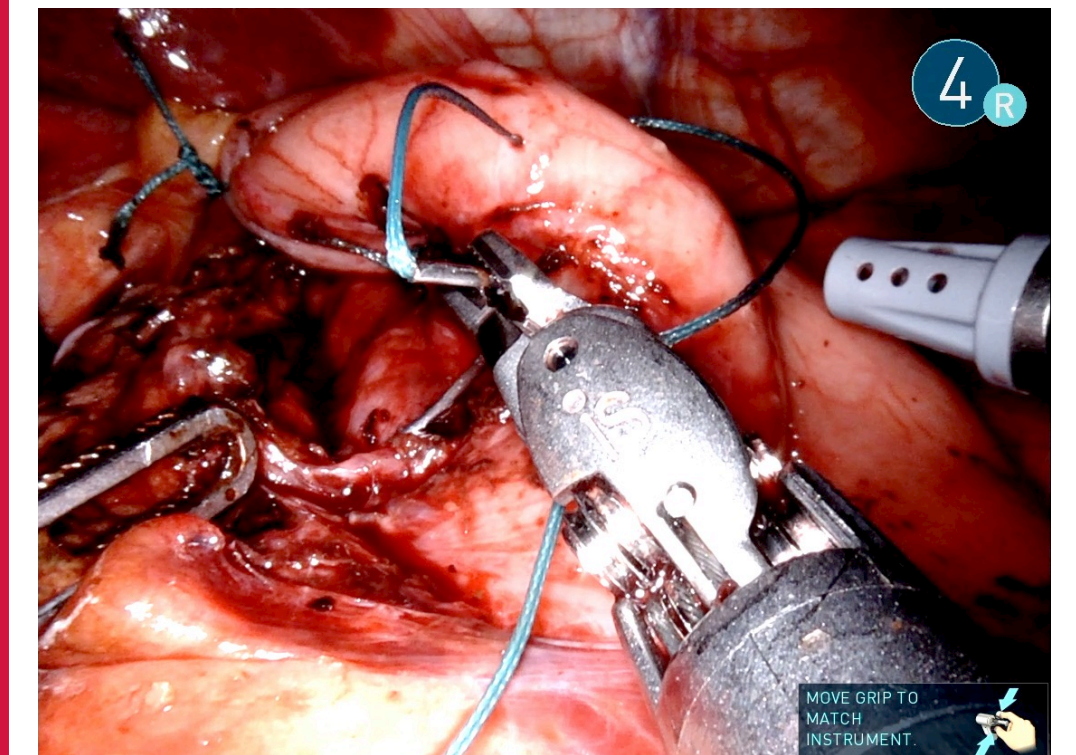
4. EGD to confirm complete myotomy



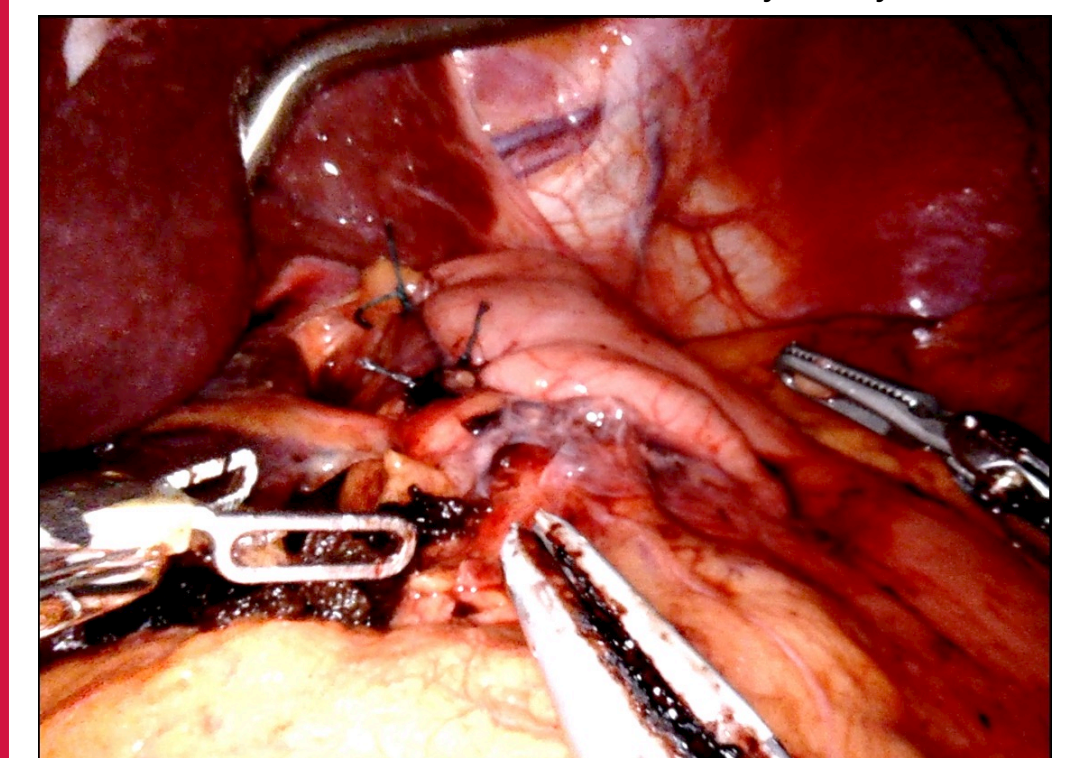
5. Suture of superior fundus with left hand behind crura



6. First suture: fundus, left crura, and edge of myotomy



7. 4th suture with fundus and myotomy



8. Completed Dor Fundoplication over myotomy