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Delayed Gastric Emptying in Robotic Pancreaticoduodenectomy and Gastrojejunostomy

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Introduction

Sympathetic while not dangerous, DGE is a typical annoying difficulty. It usually subsides quickly irrespective of its prokinetic properties and takes more than half a month when administered moderately *via* NGT exudates. The etiology of DGE is multifactorial and poorly understood. It has been speculated that pyloric denervation, loss of the pyloric siphon, gastric arrhythmia, preduodenal ischemia, motilin deficiency after duodenectomy, reduced motilin receptor activity, and exacerbations can cause DGE [1].

Description

Patient-related factors such as age, BMI, ASS class, male sex, smoking history, and bleeding incidents during surgery have been shown to be associated with an increased incidence of DGE. Pancreaticogastrostomy, length of protected proximal portion of duodenum, division of right gastric corridor, gastric/duodenal vascular resection, laparotomy, focal insight minor, colonic retrogression of gastrointestinal recovery, preoperative extensive gastric juice, long gastric cylinder status, lack of motor facilitation, diabetic gastroparesis, history of cardiovascular or renal disease, periampullary tumors, preoperative biliary waste, mechanical ventilation after activity, and gastric complications such as expulsion of the pancreas, biliary rupture, pancreatitis, and gastric ulcers. In this review, careful methodology with OPD, gastrointestinal surprise (nausea/swelling), harm, intraoperative bleeding, and lymph node metastasis were distinguished as risk factors for his DGE after pancreaticoduodenectomy. Nonetheless, none of these variables have been confirmed and are not generally accepted as contributing causes of his DGE after pancreaticoduodenectomy. This study showed a low DGE rate in RPD with extracorporeal hand-stitched gastrojejunostomy using a small umbilical lesion performed to extract the resected sample. Specific factors contributing to the reduction in DGE on multivariate assessments included type I gastrojejunostomy flow points (within 30° of vertical) between the stomach and the draining jejunal appendage, more pronounced length of the gastrojejunostomy and mechanically sutured anastomoses instead of gastrojejunostomy. Since the stomach may enter the jejunum as a potential conductor, food readily descends into this fixed position by gravity through the gastrojejunal anastomosis. We suggest that anastomosis flow may contribute to the lower DGE rate in patients with RPD. After gastrojejunostomy in patients with RPD, the final sites of gastrojejunostomy were the anterior colon near the umbilicus, antiperistaltic, and inframesocolic. The DGE rate was reduced when the gastrojejunostomy was firmly placed at the socol point in the frame without being angulated or twisted. Furthermore, they suggested that the gastrojejunostomy should be performed at an intracerebroventricular point so that it could be separated from the pancreaticojejunostomy. Separation of these two anastomoses at the mid colon may ward off or limit the exacerbating effects after pancreaticoduodenectomy or pancreatic fistula-related effects on gastrojejunostomy. Therefore, they usually place the stomach upwards and take special care to perform the gastrojejunostomy at the in-frame colonic point on the left half of the gastric cavity. Antecolic, anti-peristaltic, and in-frame socolic gastrojejunostomy can keep the stomach away from the inflammatory area that traverses the meso-colon and colon, thus reducing optional DGE in patients with RPD. MIS with injury may be one of the benefits of reducing DGE in RPD. This is because it is usually associated with decreased and worsened binding in the gastric pit [2-4].

Conclusion

On the other hand, OPD with a large gastric scar can cause significant gripping and irritation around the stomach and subsequently increase her DGE, which is optional. In summary, there are three factors that have been suggested to reduce her DGE rate in RPD patients.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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