were included. In-depth interviews were held on patient's motives for their treatment choice. First, personal motives were addressed in an open manner, and later specific topics were addressed: earlier experiences with illness and health care, future health expectations, emotional motives, religious or spiritual believes and values in life. Data was recorded, transcribed verbatim and qualitatively analyzed according to the grounded theory principles. In addition, questionnaires on health literacy, coping, anxiety and decision regret were administered at two time points.

Results: Forty patients participated: twenty preferred AS and twenty standard surgery. The central principle for all patients is striving for safety while dealing with the threat of cancer. However, patients express different coping strategies in dealing with this threat. Patients preferring AS rely on trusting their bodies and good outcomes, while questioning the need for surgery. Patients preferring surgery try to minimize insecurity by eliminating the source of the cancer, while arguing that chances for undergoing surgery are high anyway. Interestingly, for either treatment option comparable arguments were used, with the most striking one of wishing 'not to become a patient'.

Conclusion: Patients' preferences in the treatment of esophageal cancer are determined by the way they cope with the threat of cancer. Since the arguments given for either AS or standard surgery can be comparable or even similar, the need for healthcare professionals to discuss what truly matters to their patients is of high importance. Subsequently, attuning to the personal needs of esophageal cancer patients will benefit the decision making process on future treatment.

766 PROPHYLAXIS OF POST-FUNDOPLICATION SIDE EFFECTS AFTER LAPAROSCOPIC NISSEN EXTRA SOFT FUNDOPLICATION.

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Laparoscopic Nissen Fundoplication (LNF) is well-established surgical treatment of GERD with best long-term postoperative outcomes in controlling reflux. Usually it is associated with a high risk of dysphagia, flatulence, inability to belch, bloating, which appear due to total over-tight wrap around esophagus. Partial fundoplication can avoid these effects, but unfortunately does not have the same long-term postoperative reflux control. So, new approach to prophylaxis of post-fundoplication side effects during LNF is needed.

Methods: Modified extra-soft LNF for GERD during 2016–2020 years were proposed in 75 patients. Prior to the fundoplication wrap formation the operation was performed according to the standard procedure. The proposed surgical techniques were: performing of an extra mobilization of the stomach (mandatory fundus and more $^1/_2$ part of a large curvature) by crossing the gastro-splenic ligament completely and the gastro-colonic ligament partially and formation of a short extra-soft fundoplication wrap around the esophagus less 1.5 cm in the length with no more than 3 non-absorbable sutures with obligatory fixation to the esophagus. We examined twelve months follow-up.

Results: Along with the disappearance of GERD symptoms, no post-fundoplication dysphagia, flatulence, inability to belch and bloating were marked in any patient. Routine application of the above-described techniques allowed us to perform a modified LNF in all 75 patients by the extra mobilization of the stomach and formation of an extra-soft total fundoplication wrap with obligatory fixation to the esophagus without mandatory use of a thick (56–60 Fr) gastric fundoplication tube.

Conclusion: According to our study, in comparison with standard LNF, the proposed surgical techniques is effective in the prevention of post-fundoplication complications (dysphagia, flatulence, inability to belch, bloating) and support routine use of this modified Laparoscopic Nissen Extra Soft Fundoplication in treatment of GERD.

770 CONSIDERABLE EFFECT OF UPPER MEDIASTINAL LYMPHADENECTOMY UNDER LAPAROSCOPIC ASSISTED SINGLE-PORT INFLATABLE MEDIASTINOSCOPY THROUGH LEFT NECK APPROACH

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Conventional minimally invasive esophagectomy requires transthoracic surgery, which could increase the risk of many perioperative complications. Mediastinoscopy-assisted transhiatal esophagectomy has been proposed for years, but the traditional methods have shortcomings, such as unclear vision, especially during the dissection of upper mediastinal lymph nodes. We proposed a novel approach of upper mediastinal lymphadenectomy with mediastinoscopy through a left-neck incision, and investigated the effect of lymphadenectomy and other perioperative outcomes.

Methods: This approach for upper mediastinal lymphadenectomy includes three parts. (I) Lymphadenectomy along the left recurrent laryngeal nerve (RLN) could be accomplished during esophagectomy under mediastinoscopy. (II) At the level of the lower edge of the right subclavian artery (RSA), between the trachea and the esophagus, instruments are used to access the right RLN. Lymphadenectomy of up to 2 cm could be accomplished at the upper edge of the RSA. (III) Between the trachea and esophagus, the left and right main bronchi are exposed along the trailing edge of the trachea down to the carina, and lymphadenectomy can be performed here.

Results: This lymphadenectomy had been completed successfully on 117 patients, and 1 was converted to thoracotomy due to intraoperative tracheal membrane damage. The average operation time was 181.4 ± 43.2 minutes, bleeding volume was 106.4 ± 87.9 mL. The number of dissected LNs of upper mediastinal, the left RLN, the right RLN and the subcarinal was 11.2 ± 6.3, 5.1 ± 2.8, 3.2 ± 1.3 and 3.8 ± 2.1 respectively. 10 cases of (8.5%) anastomotic fistula were resolved with proper drainage and nutritional support. There were 25 cases (21.2%) of anastomotic strictures, 10 cases (8.5%) of pleural effusion, 20 cases (16.9%) of hoarseness. The incidence of hoarseness was 2.5% in three months postoperation.

Conclusion: These results showed that the lymphadenectomy through the left neck approach was not inferior than other surgical approaches in the amount of upper mediastinal LNs resection and perioperative outcome. Further research is needed to discover its impact on the long-term prognosis of ESCC patients.

771 IMPACT OF NATIONWIDE CENTRALIZATION OF ESOPHAGEAL, GASTRIC, AND PANCREATIC SURGERY ON TRAVEL DISTANCE AND EXPERIENCED BURDEN IN THE NETHERLANDS

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This study aims to assess the impact of nationwide centralization of surgery on travel distance and travel burden among patients with esophageal-, gastric-, and pancreatic cancer according to age in the Netherlands. As centralization of care increases to improve postoperative outcomes, travel distance and experienced burden might increase.

Methods: All patients who underwent surgery between 2006–2017 for esophageal-, gastric- and pancreatic cancer in the Netherlands were included. Travel distance between patient's home address and hospital of surgery in kilometers was calculated. Questionnaires were used to assess experienced travel burden in a subpopulation (n = 239). Multivariable ordinal logistic regression models were constructed to identify predictors for longer travel distance.

Results: Over 23,838 patients were included, in whom median travel distance for surgical care increased for esophageal cancer (n = 9,217) from 18 to 28 km,