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Published in:
Surgical Endoscopy

DOI:
[10.1007/s00464-019-06675-4](https://doi.org/10.1007/s00464-019-06675-4)

Publication date:
2019

Document Version
Peer reviewed version

[Link to publication in Discovery Research Portal](#)

Citation for published version (APA):

Köhler, H., Jansen-Winkeln, B., Maktabi, M., Barberio, M., Takoh, J., Holfert, N., Moulla, Y., Niebisch, S., Diana, M., Neumuth, T., Rabe, S. M., Chalopin, C., Melzer, A., & Gockel, I. (2019). Evaluation of hyperspectral imaging (HSI) for the measurement of ischemic conditioning effects of the gastric conduit during esophagectomy. *Surgical Endoscopy*, 33(11), 3775-3782. <https://doi.org/10.1007/s00464-019-06675-4>

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Evaluation of hyperspectral imaging (HSI) for the measurement of ischemic conditioning effects of the gastric conduit during esophagectomy

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Abstract

Background. Hyperspectral imaging (HSI) is a relatively new method used in image-guided and precision surgery, which has shown promising results for characterization of tissues and assessment of physiologic tissue parameters. Previous methods used for analysis of preconditioning concepts in patients and animal models have shown several limitations of application. The aim of this study was to evaluate HSI for the measurement of ischemic conditioning effects during esophagectomy.

Methods. Intraoperative hyperspectral images of the gastric tube through the mini-thoracotomy were recorded from n=22 patients, 14 of whom underwent laparoscopic gastrolisis and ischemic conditioning of the stomach with two-step transthoracic esophagectomy and gastric pull-up with intrathoracic anastomosis after 3 - 7 days. The tip of the gastric tube (later esophago-gastric anastomosis) was measured with HSI. Analysis software provides a RGB image and 4 false color images representing physiologic parameters of the recorded tissue area intraoperatively. These

1 parameters contain tissue oxygenation (StO_2), perfusion- (NIR Perfusion Index),
2 organ hemoglobin- (OHI) and tissue water index (TWI).

3 **Results.** Intraoperative HSI of the gastric conduit was possible in all patients and did
4 not prolong the regular operative procedure due to its quick applicability. In particular,
5 the tissue oxygenation of the gastric conduit was significantly higher in patients who
6 underwent ischemic conditioning ($\overline{StO_2}_{Precond.} = 78\%$; $\overline{StO_2}_{NoPrecond.} = 66\%$; $p = 0.03$).

7 **Conclusions.** HSI is suitable for contact-free, non-invasive and intraoperative
8 evaluation of physiological tissue parameters within gastric conduits. Therefore HSI is
9 a valuable method for evaluating ischemic conditioning effects and may contribute to
10 reduce anastomotic complications. Additional studies are needed to establish normal
11 values and thresholds of the presented parameters for the gastric conduit
12 anastomotic site.

14 **Keywords**

15 Hyperspectral imaging – gastric conduit – esophagectomy – ischemic conditioning –
16 physiologic tissue parameters

18 **Introduction**

19 Esophago-gastric anastomosis following esophageal resection and gastric pull-up is
20 one of the most complex anastomoses of the gastrointestinal tract with a high
21 potential of insufficiency and consecutive complications, as mediastinitis, pleural
22 empyema, esophago-tracheal (-bronchial) fistula and septic arrosion bleeding (1). This
23 high risk procedure of esophagectomy has been reported in the literature to be
24 associated with a significant morbidity (>40%) and mortality (5-12%) (2,3). During the
25 process of gastric tube formation in the context of esophagectomy, the major blood
26 vessels of the stomach, such as the left gastric artery and vein, the left gastroepiploic
27 artery and vein, as well as the short gastric vessels are divided, with immediate
28 ischemic reaction of the stomach wall. Viability of the gastric conduit then, however,
29 is mostly dependent on the right gastroepiploic arcade. It has been well analyzed by
30 optical fiber spectroscopy (OFS) that oxygen saturation (SaO_2) and blood flow are
31 significantly reduced during this stepwise devascularization of the stomach and that
32 the extent of resulting gastric tube ischemia is associated with clinical outcomes, e.g.
33 anastomotic leaks (4). The stimulus by relative ischemia following division of major
34 vessels, thus, leads to microvascular improvement by neovascularization (5),

1 especially in the later area of the anastomotic site at the tip of the gastric conduit. The
2 concept of preconditioning, including a two-time procedure with an interval of several
3 days to 2-3 weeks between vessel ligation, gastrolysis and gastric tube transposition
4 into the thorax with anastomosis, is well known as ischemic conditioning (delay
5 phenomenon) of the stomach. This method was first described by Urschel in a rat
6 model (6) and further clinically elaborated and laparoscopically applied by Nguyen et
7 al. in a small series of n=9 patients (7), and in the first large retrospective cohort
8 (n=83 patients) by Hölscher et al. (8) and later comparatively by Schröder et al.
9 (n=419; 238 with ischemic conditioning) of the same clinic (9). During the time period
10 between the first and second intervention and the subsequent delayed transposition
11 and esophagogastric anastomosis, the gastric fundus has time to re-establish an
12 abundant blood supply (10). In general, this partial gastric devascularization can
13 technically be performed by open, laparoscopic or robotic surgery. In addition,
14 preoperative radiologic-interventional arterial embolization has been shown to be
15 equally successful (11–16).

16
17 Although previous methods used for measuring the effects have shown several
18 limitations and are rather time-consuming, the results of this preconditioning concept
19 have been convincing ever since, demonstrating reduction of anastomotic
20 complications following esophagectomy and gastric pull-up in patients and animal
21 models, due to improved perfusion as well as reduced inflammation and fibrosis at
22 the anastomotic site of the gastric sleeve (8,9,17,18). These parameters are known
23 to be the most important factors for regular healing, apart from tension-free and
24 technically perfect performance of the anastomosis. Animal studies have provided
25 evidence that perfusion was 3 times better at re-intervention after ischemic
26 conditioning, going along with increased vasodilation and angiogenesis, less
27 anastomotic collagen deposition, less ischemic injury, and less muscularis atrophy
28 (19). In clinical studies, especially the severity of anastomotic leakage could be
29 reduced significantly (9,20–22). However, a prospective randomized trial (LOGIC trial
30 = laparoscopic gastric ischemic conditioning prior to minimally invasive
31 esophagectomy) by Veeramootoo et al. failed to show improvement of perfusion at
32 the conduit tip (2). In this study, perfusion of the fundus and the greater curvature of
33 the stomach was recorded by laser Doppler fluximetry, which was validated to assess
34 gastric perfusion by others (23,24). A perfusion coefficient measured as ratio at stage

1 of MIE (minimally invasive esophagectomy) over baseline was used for statistical
2 analysis (2). Others, as the group of Hölscher and Schröder, performed mucosal
3 oxygen saturation (MOS, sulfur dioxide in %) measurements quantitatively from the
4 endoluminal side in well-defined areas of the antrum, corpus and fundus, using a
5 tissue spectrometer located at the tip of a microprobe (8,9,25). In an attempt to
6 search for further reliable methods to assess gastric conduit perfusion, Pham et al.
7 applied optical fiber spectroscopy (OFS) to measure oxygen saturation (SaO₂) and
8 blood volume fraction (BVF) in the distal gastric conduit at baseline and after gastric
9 devascularization, conduit formation, and transposition, with correlation of these
10 readings with clinical outcomes (4). Functional capillary density in ischemic
11 conditioning was assessed by Mittermair et al. in rats in order to investigate time
12 dependent changes of gastric microcirculation by means of intravital fluorescence
13 microscopy (26). Recently, indocyanine green (ICG) fluorescence has been
14 described for evaluating blood supply of the reconstructed tube during
15 esophagectomy (27–29). However, apart from the fact that ICG is an invasive
16 procedure with a considerable rate of cardiovascular complications, comparative
17 studies, regarding the value of ICG in ischemic conditioning of the gastric conduit, are
18 still lacking.

19
20 The aim of this study was to evaluate the feasibility of hyperspectral imaging (HSI) for
21 the measurement of ischemic conditioning effects during esophagectomy.

22 23 **Patients and methods**

24 Only patients who underwent hybrid (abdominal part: minimally-invasive; thoracic
25 part: mini-thoracotomy) or open esophagectomy (n=1 with simultaneous liver
26 resection, see below) could be included, because the used HSI-camera is too large
27 for laparoscopic surgery. Intraoperative hyperspectral images of the gastric tube
28 through the mini-thoracotomy were recorded from n=22 patients (20 males, 2 female)
29 with a median age of 64 (36 - 82) years. Involved were 12 adeno-, 9 squamous-cell
30 carcinomas of the esophagus and 1 reconstruction with gastric pull-up after
31 esophagectomy due to perforation (no carcinoma of the esophagus). In the group of
32 patients undergoing ischemic preconditioning, laparoscopic gastrolisis and ischemic
33 conditioning of the stomach was performed 3-7 days before the operation in n=14 of
34 the 22 patients. In detail, during laparoscopic gastrolisis, first, the lesser omentum

1 close to the lower edge of the liver, then the greater omentum (including the left
2 gastroepiploic artery and vein) is divided, preserving the gastroepiploic arcade. The
3 left gastric artery and vein are clipped and cut centrally, harvesting the lymph nodes
4 of the celiac trunc, and finally, the short gastric vessels are divided up to the left crus.
5 If possible, the right gastric artery and vein are preserved. Kocher's maneuver of the
6 duodenum is carried out and the distal esophagus with the periesophageal lymph
7 nodes is mobilized intrathoracically as far as possible. Patients were sent to the
8 peripheral ward afterwards and could eat a soft diet. The second step of the
9 operation after ischemic conditioning of the stomach consisted of transthoracic
10 esophagectomy via a mini-thoracotomy (in the sense of a hybrid-procedure) with
11 completion of the two-field lymphadenectomy, gastric tube formation by resection of
12 the lesser curvature and adjacent nodes with a linear stapler (from proximal to distal),
13 and intrathoracic end-to-side esophagogastric anastomosis (circular stapler, EEA 25
14 mm) at the level of the azygos vein.

15 The decision on whether to perform ischemic conditioning or not was due to the time
16 interval of surgery: After January 1st 2018, we completely changed our concept
17 towards two-step esophagectomies with ischemic gastric preconditioning in general.
18 Conclusively, patients measured before this point in 2017 underwent the single-step
19 esophagectomy without preconditioning. In one patient, simultaneous liver
20 metastatectomy was performed (segment IV) during open gastrolisis and ischemic
21 conditioning of the stomach. All patients underwent intrathoracic anastomosis, except
22 for the gastric tube pull-up reconstruction following esophagectomy, where we
23 performed a cervical esophago-gastric anastomosis. Clinical data of patients are
24 summarized in **Table 1**.

25 Immediately before construction of the esophago-gastric anastomosis (stapled end-to
26 side, EEA 25 mm circular stapler system) the hyperspectral images were acquired
27 with the TIVITA™ Tissue system (Diaspective Vision GmbH, Am Salzhaff, Germany).
28 This HSI-camera has a push broom scanner providing images with a high spectral
29 resolution (5 nm) in the visible and near infrared range (500-1000 nm). The Number
30 of Effective Pixels is 640 × 480 (x-, y-axis). All measurements were taken at a
31 distance of 30 cm between the object and the camera lens with a focal length of 25
32 mm. This setup results in a field of view (FOV) of 6.4 × 4.8 cm² and a spatial
33 resolution of 0.1 mm/pixel. Illumination is done by 8 halogen spots (20 W each) which
34 are directly integrated in the camera housing. For accurate measurements, the

1 ceiling lights in the operating room were switched off during image recording
2 (approximately 10 seconds). After a computation time of 8 seconds, the analysis
3 software provides a RGB image and 4 false color images that represent physiologic
4 parameters of the recorded tissue area intraoperatively. These parameters contain
5 tissue oxygenation (StO_2), perfusion- (NIR Perfusion Index), organ hemoglobin-
6 (OHI) and tissue water index (TWI). The relative blood oxygenation in the
7 microcirculation of superficial tissue layers (approximately 1 mm) is represented by
8 StO_2 [%], while the NIR Perfusion Index [0-100] represents tissue layers in 4-6 mm
9 penetration depth. The indices OHI [0-100] and TWI [0-100] display the distribution of
10 hemoglobin and water in the observed tissue area, respectively. A detailed
11 description and validation of the parameters can be found in the work of Holmer et
12 al.(30).

13 The location of the later anastomosis was depicted by a forceps during the
14 measurement **Fig. 1**. The area within the diameter of 25 mm around the marked
15 position is called region of interest (ROI). For each parameter image the index
16 average was calculated from the values inside the ROI.

17 Data were collected prospective and analyzed retrospective with LabVIEW. Statistics
18 of physiological parameter indices are presented in mean, median, quartiles and p-
19 value. The f-test was performed to check for equal variances and unpaired two-tailed
20 Student's t-test was used to determine statistical significance. The statistical analyses
21 were performed with Microsoft Excel 2013.

22 **Results**

23 Intraoperative hyperspectral imaging of the tip of the gastric tube (later anastomosis)
24 was possible through mini-thoracotomy in all our patients undergoing hybrid or open
25 (n=1 patient with simultaneous liver resection during gastrolisis) esophagectomy.
26 HSI measurements did not prolong the regular operative procedure due to its quick
27 applicability (10 seconds per recording and its almost “real-time” possibility of
28 visualization and interpretation). In particular, HSI enabled to distinguish between
29 gastric sleeves with and without ischemic conditioning: A significantly lower mean
30 oxygenation inside the ROI of the gastric conduit was observed in patients without
31 pretreatment (one-step esophagectomy) ($\overline{StO_2}_{NoPrecond.} = 66\%$) compared to patients
32 with ischemic preconditioning ($\overline{StO_2}_{Precond.} = 78\%$; $p = 0.03$). Even though not
33 significant, differences in organ hemoglobin index ($\overline{OHI}_{NoPrecond.} = 42$; $\overline{OHI}_{Precond.} = 46$;
34

1 p = 0.51) and tissue water index ($\overline{\text{TWI}}_{\text{NoPrecond.}} = 59$; $\overline{\text{TWI}}_{\text{Precond.}} = 63$; p = 0.50) were
2 found for both patient groups. Median, lower and upper quartiles of the ROI mean
3 index for each parameter are summarized in **Table 2** and the distribution among the
4 patients is described in **Fig. 2**.

5 The postoperative course was uneventful in all patients with regular healing and
6 timely oral nutrition following surgery, except for one non-preconditioned patient. This
7 patient developed a small anastomotic leak of the intrathoracic anastomosis without
8 mediastinitis or sepsis on postoperative day 7, which could be managed
9 conservatively using endoscopic vacuum therapy (Endosponge).

11 **Discussion**

12 Our data clearly show for the first time the feasibility and reliability of hyperspectral
13 imaging (HSI) measuring the ischemic conditioning effects of the gastric conduit and
14 the discrimination possibility to non-preconditioning during esophagectomy. Previous
15 methods used for this analysis in patients and animal models have shown several
16 limitations of application and usefulness and are time-consuming.

17 The studies supporting the concept of ischemic conditioning, including an animal
18 experiment (8,9,17,18), are of non-randomized character. However, the only
19 prospective-randomized trial (LOGIC trial) (2), did not confirm the benefits claimed for
20 ischemic conditioning. This study might have been underpowered and the final
21 endpoint, anastomotic insufficiency, is known to be multifactorial, strongly depending
22 on the surgeon's technique. A more sophisticated endpoint would have been
23 vascularization of the tip of the gastric tube.

24 HSI is a relatively new method used in image-guided and precision surgery, which
25 has shown promising results for recognition/characterization of tissues/tumors (31–
26 36), and comprehensive assessment of physiologic tissue parameters, such as
27 perfusion, oxygenation, and water content (37–40). Hence, it has been applied
28 predominantly in wound imaging and -management in plastic surgery transplants,
29 vascular surgery, chronic wounds and burn injuries so far (41–44). In our study
30 group, we were able for the first time to use the system to assess tissue parameters
31 of gastrointestinal anastomoses in visceral surgery *in vivo* (40). HSI, as a contact-
32 free, non-invasive method with no need of contrast medium, provides objective “real
33 time” perfusion-, oxygenation and hydration evaluation of organs and especially of
34 anastomotic sites intraoperatively, which can possibly contribute to determining the

1 “ideal” region of anastomosis with the intent of improved healing (40). HSI-
2 measurements of the gastric conduit during esophagectomy, especially in the context
3 of ischemic conditioning, have not been published so far to our knowledge.

4 The applied HSI-technology in our current study has a relevant advantage over
5 conventional multispectral camera systems due to its higher spectral and spatial
6 resolution. Furthermore, our HSI-camera provides a higher penetration depth
7 compared to the technology of digital cameras (0-1 mm). Thus, deeper tissue layers
8 can be reached by the HSI-camera.

9 Optical fiber spectroscopy (OFS) can be used for the assessment of tissue
10 oxygenation during laparoscopic procedures (4,25). However, OFS covers only a
11 small spot (3 mm) and therefore multiple measurement points are needed, which
12 increases the measuring time. The HSI-camera used in this study is able to cover a
13 large FOV ($6.4 \times 4.8 \text{ cm}^2$) and a wavelength range up to 1000 nm, which enables the
14 additional analysis of tissue water at 960 nm. Other groups determined changes in
15 gastric blood flow with laser Doppler flowmetry, but did not find significant differences
16 between patients with and without ischemic conditioning (2,45). Blood flow cannot be
17 estimated with HSI, but therefore other perfusion-related parameters, like
18 oxygenation and hemoglobin distribution, which seem to be more promising for the
19 analysis of ischemic conditioning effects.

20 In contrast to the increasingly applied technology of Near-InfraRed (NIR)-
21 fluorescence with ICG, which has especially been used in colorectal surgery to
22 reduce anastomotic complications, as impressively shown by the PILLAR II
23 multicenter study (46), the non-invasiveness of our HSI-technology has to be pointed
24 out. Serious and life-threatening side-effects after intravenous application of ICG,
25 such as anaphylactic shock, drop in blood pressure, tachycardia, dyspnea, and
26 urticaria, have been described and the risk of significant adverse and secondary
27 effects rises in patients with chronic renal failure, up to sudden deaths in very rarely
28 reported cases. A further disadvantage of ICG is the subjective evaluation of the
29 fluorescence-intensity by pure envisioning of the surgeon and, thus, reflects its
30 limitations. A new method, called fluorescence-based enhanced reality (FLER), which
31 uses fluorescence time-to-peak was described by Diana et al. (47–49) and showed
32 promising results regarding quantitative ICG-measurement of bowel perfusion in the
33 animal model.

1 In addition, providing comprehensive tissue parameters, such as tissue oxygenation
2 (StO₂), perfusion- (NIR Perfusion Index), organ hemoglobin- (OHI) and tissue water
3 index (TWI), it might be a valuable tool to select the “ideal” anastomotic site of the
4 esophagogastric anastomosis, in order to reduce the risk of leakage. This could be
5 carefully concluded, although casuistic only, by one case of our series, who
6 developed anastomotic insufficiency of the intrathoracic esophago-gastric
7 anastomosis. In this patient, the intraoperative measurements were relevantly lower
8 than the others: StO₂ = 41% (Diff. to $\overline{\text{StO}_2}_{\text{NoPrecond.}}$ = 25%), NIR Perfusion Index = 40
9 (Diff. to $\overline{\text{NIR}}_{\text{NoPrecond.}}$ = 22), OHI = 25 (Diff. to $\overline{\text{OHI}}_{\text{NoPrecond.}}$ = 17). In **Fig. 3** the NIR
10 Perfusion Index image of this patient is compared to a case without postoperative
11 anastomotic leak.

12 The intraoperative measurements are less time-consuming than most other
13 technologies used for assessment of ischemic conditioning effects (about 18 seconds
14 per document), non-invasive, and contact-free. Additionally, they can be technically
15 very easily performed (e.g. by an OR nurse). However, normal and “cut-off” values
16 for gastrointestinal (tubular) organs, especially for different anastomoses, or the
17 “optimal” gastric conduit status (with and without ischemic conditioning), are still to be
18 defined and established, as the technology mainly derives from wound imaging and
19 management. In the latter, e.g. in plastic and vascular surgery, oxygenation of > 50%
20 predicts a good healing of a wound, whereas 30-50% represent a “grey area”, and
21 values of < 30% are associated with worse healing processes in transplants and
22 chronic wounds (50,51). After establishing and generation of normal values and
23 borderline zones of the gastric conduit anastomotic site, the method will be very
24 helpful to determine the best area of perfusion with the optimal constellation of
25 additional parameters, such as oxygenation and edema, in order to avoid
26 postoperative leakages. With regard to the TWI, we found higher values in the group
27 undergoing ischemic preconditioning. This might be due to the fact that patients
28 received additional fluid therapy following laparoscopic gastrolisis and partial
29 devascularization, as some of them displayed signs of minor gastroparesis after this
30 first step of surgery and enteral nutrition was slightly restricted to prevent aspiration
31 events.

32 The used HSI-system is intended for use in plastic surgery and wound diagnostics.
33 For applications in visceral surgery, according to the manufacturer’s website, some
34 improvements are currently under development or planned for the future. This

1 includes focused illumination with LEDs to light up structures deep in the situs and
2 correct for ambient light during open surgery. This also holds for the automatic
3 estimation of the object distance to get a focused image. A major advance will be a
4 compact HSI-camera, which is suitable for laparoscopic procedures and provides
5 high resolution videos.

6 The encountered limitations of HSI for measuring the ischemic conditioning effects of
7 the gastric conduit are the missing gold standard for estimating tissue oxygenation,
8 which makes it difficult to compare it with other methods. The time currently needed
9 for hyperspectral data acquisition and parameter calculation is short (18 seconds) but
10 still not yet fully “real time”, a minor downside compared to ICG-imaging, which shall
11 be improved in the near future.

12 **Conclusions**

13 Intraoperative HSI during mini-thoracotomy was used for the evaluation of ischemic
14 conditioning effects. Mean tissue oxygenation and hemoglobin related indices at the
15 later anastomosis location were higher in patients with ischemic preconditioning than
16 without. One patient with noticeable lower values developed anastomotic
17 insufficiency. This work demonstrates, that HSI is suitable for contact-free, non-
18 invasive and rapid intraoperative evaluation of physiological tissue parameters within
19 gastric conduits. Therefore HSI is a valuable method for evaluating ischemic
20 conditioning effects and may contribute to reduce anastomotic complications.

21 **Disclosures**

22 *Conflicts of Interest:* The hyperspectral camera used for the measurements in this
23 publication was developed by Diaspective Vision GmbH. H. Köhler is employee of
24 this company. In the long term, Diaspective Vision has proprietary interest in the
25 development of the camera system resulting in a product for routine clinical use. The
26 clinical tests of the camera have been performed by clinicians (authors 2, 4-8 and
27 11). B. Jansen-Winkel, M. Maktabi, M. Barberio, J. Takoh, N. Holfert, Y. Moulla, S.
28 Niebisch, M. Diana, T. Neumuth, S. M. Rabe, C. Chalopin, A. Melzer and I. Gockel
29 have no financial interests and financial arrangements with Diaspective Vision and
30 have received no funding for the measurements and/or preparation of this
31 manuscript. The cameras used during the measurements have been provided by
32 Diaspective Vision.

1 *Funding:* Authors state no funding involved.

2 Ethical approval: Experimental hyperspectral measurements from patients for the
3 evaluation of the new technology have obtained the ethics approval by the Ethics
4 committee of the University Leipzig under 026/18-ek. The study was conducted
5 according to the Declaration of Helsinki.

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36

Table 1 Patient demographics and tumor histology

Variables	Ischemic preconditioning	
	Yes (n=14)	No (n=8)
Median age [range] in years	63 [36 - 77]	68 [52 - 82]
Sex, n (males : females)	13 : 1	7 : 1
Tumor type		
Adenocarcinoma	7	5
Squamous-cell carcinoma	7	2
None	-	1
Tumor localization		
Lower third of the esophagus	8	4
Lower and middle third	-	1
Middle third	5	2
Upper third	1	-
None	-	1
Neoadjuvant therapy		
Chemotherapy	4	4
Chemo radiotherapy	9	2
Radiotherapy	1	-
None	-	2

Table 1 Statistics of ROI mean index of measured gastric tubes for each parameter

Parameters Median [lower-, upper quartile]	Ischemic preconditioning		P value
	Yes (n=14)	No (n=8)	
Tissue oxygenation (StO ₂)	0.78 [0.71, 0.82]	0.69 [0.55, 0.80]	0.03
NIR Perfusion Index	0.68 [0.61, 0.72]	0.62 [0.59, 0.70]	0.22
Organ hemoglobin index (OHI)	0.52 [0.42, 0.57]	0.43 [0.31, 0.49]	0.51
Tissue water index (TWI)	0.63 [0.53, 0.72]	0.55 [0.51, 0.62]	0.50

Fig. 1 RGB image with marked ROI at later anastomosis location (left) and false color image of tissue oxygenation (right).

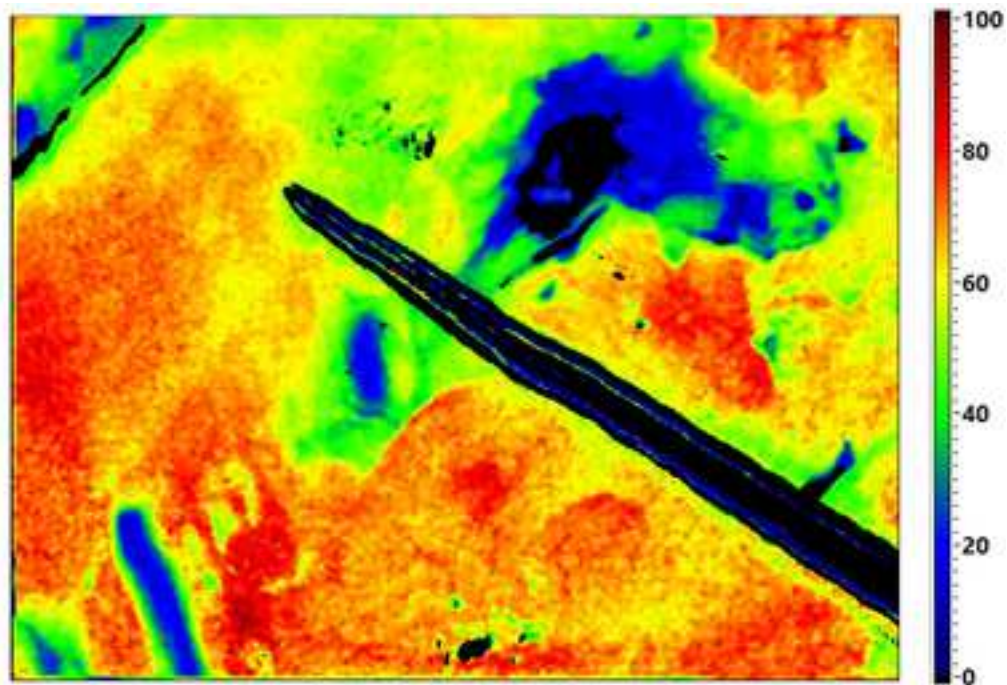
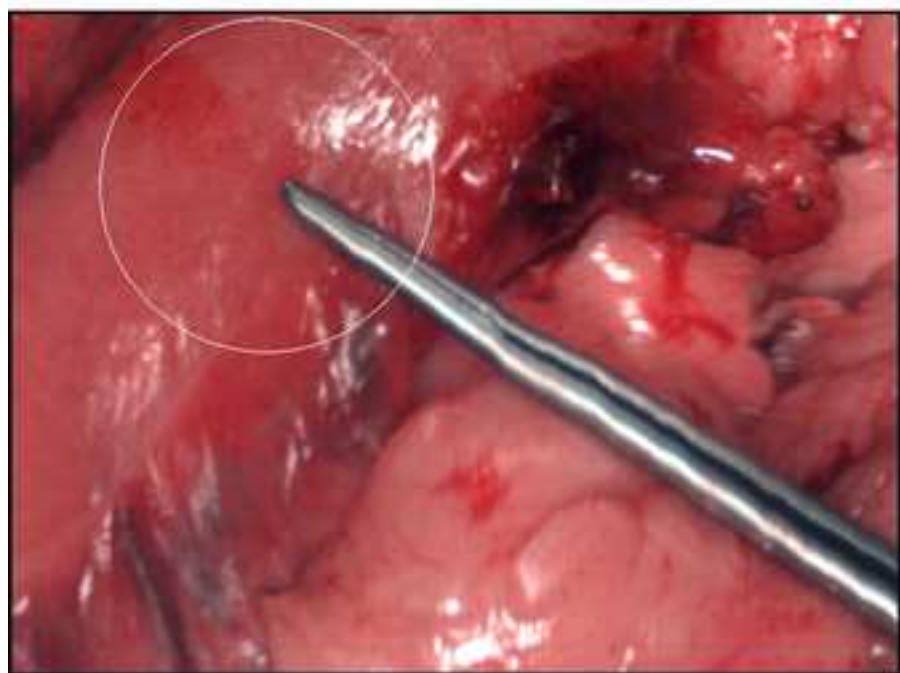


Fig. 3 RGB- and NIR Perfusion Index- images of a patient with (A, B) and without postoperative anastomotic insufficiency (C, D).

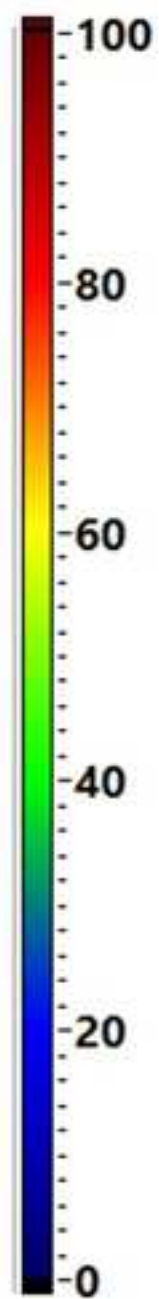
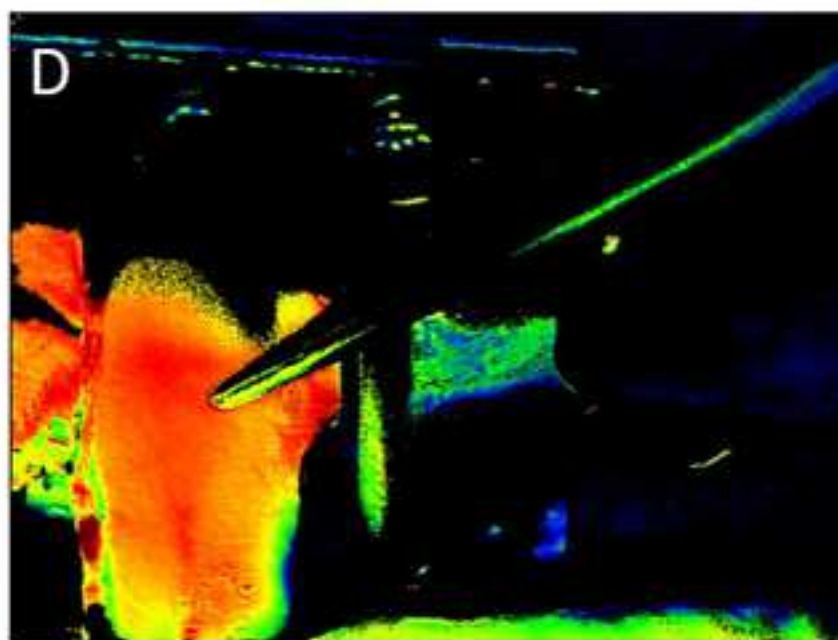
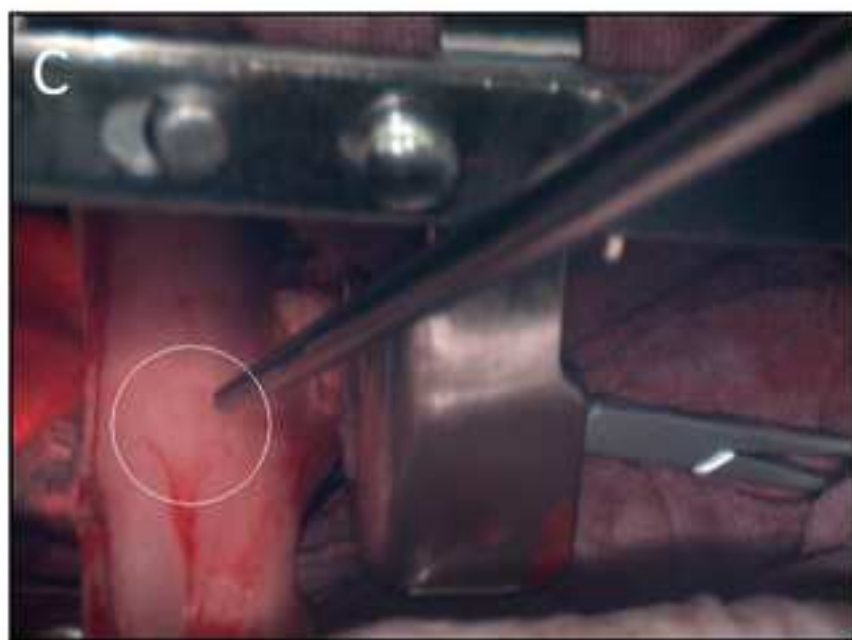
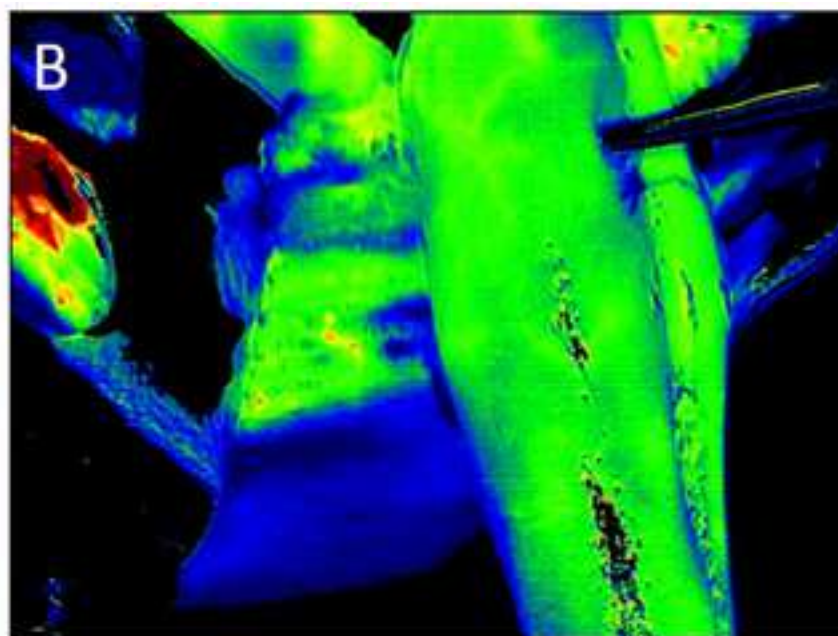
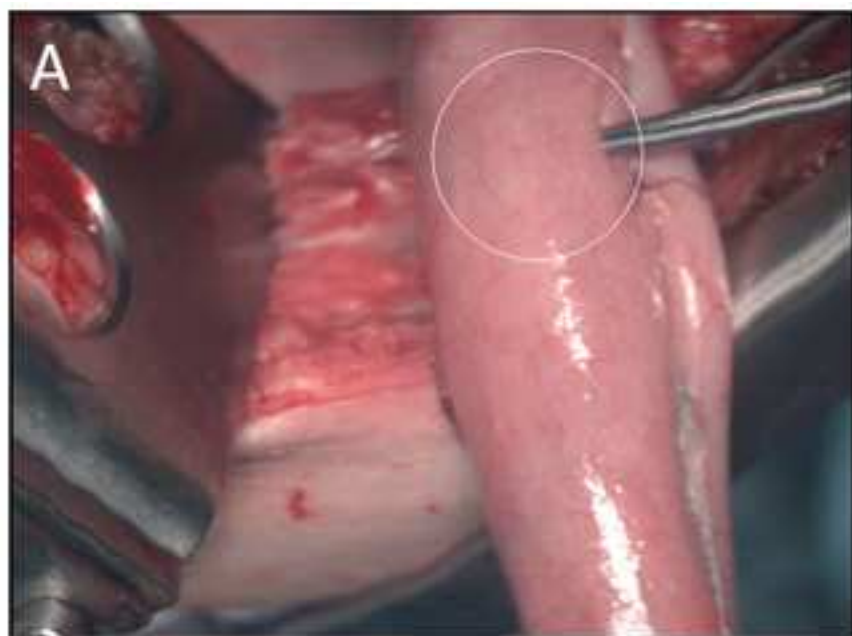


Fig. 2 Distribution of the index average inside the ROI among patients with and without ischemic preconditioning for a) tissue oxygenation (StO₂), b) perfusion- (NIR Perfusion

