

Enormous Single-Session Septotomy for the Treatment of Late Leak Postsleeve Gastrectomy

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CASE REPORT

Endoscopic septotomy is a technique in which an incision is made to enlarge the fistulous tract between the sleeve lumen and perigastric collection, resulting in removal of the pressure gradient that drives the leak.¹

A 52-year-old man with a history of laparoscopic sleeve gastrectomy presented 8 weeks postoperatively with acute symptoms of abdominal pain, nausea, vomiting, and inability to tolerate oral intake. A previous attempt of primary closure with endoscopic suturing using the Apollo OverStitch was unsuccessful (Figure 1). A week later, a partially covered self-expandable metal stent 18 mm × 15 cm was placed to create a watertight seal across the leak site. However, this also failed to close the leak, and the decision was made to move from a strategy of closure to keeping the fistula open because this was now classified as a late leak present at more than 12 weeks postsleeve gastrectomy.^{2,3} Treatment options included double pigtail, endoscopic septotomy, and endoscopic vacuum therapy.

The patient agreed to undergo septotomy with stent removal. Esophagogastroduodenoscopy showed the perigastric cavity tracking downstream along the stomach with the staple line visible at the 4 o'clock position when the endoscope is in the perigastric cavity (Figure 2). The cavity was estimated to be approximately 10 cm in length. A single-session, complete septotomy was performed using a stag beetle knife standard knife (Olympus) with a blended electrosurgical current.⁴ There was no gastric stenosis at the incisura angularis. The patient was discharged on the same day on a clear fluid diet for 3 days, a full fluid diet for 11 days, and a normal diet thereafter.

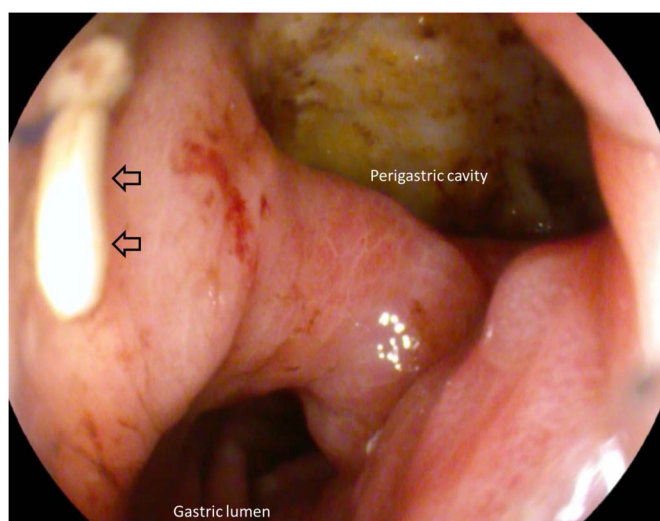


Figure 1. Epithelialized leak orifice measuring about 14 mm in diameter with suture material from the previously attempted closure (black arrows).

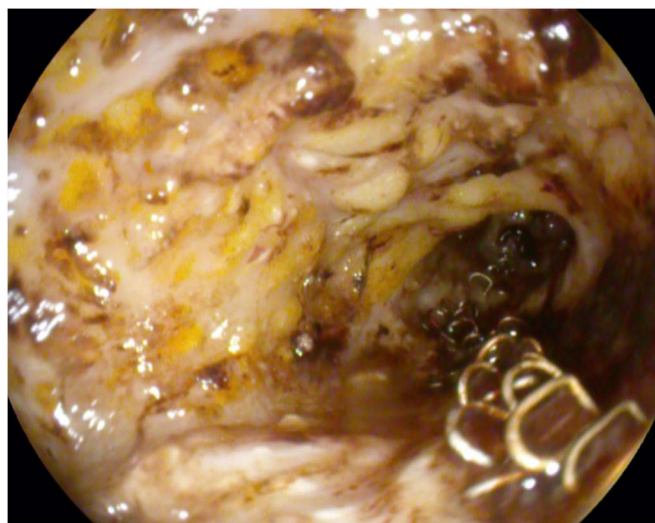


Figure 2. A large 10-cm perigastric cavity. Note the staple line at the 4 o'clock position.

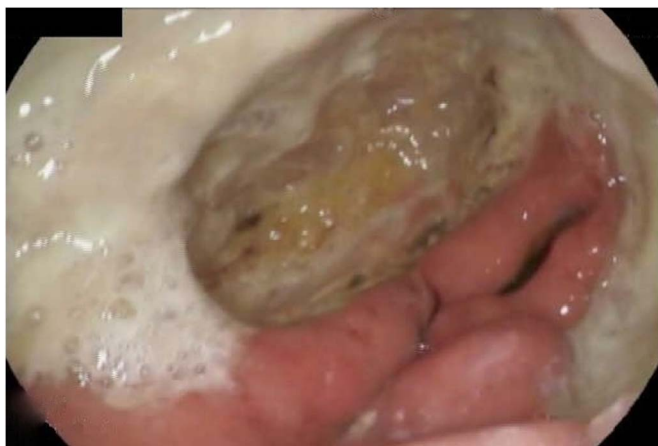


Figure 3. Endoscopic view from the mid-distal gastric lumen 4 weeks after septotomy shows the continuation of the gastric lumen with the perigastric cavity.

The patient progressed well and tolerated a normal diet, although he had postprandial epigastric discomfort. A repeated esophagogastroduodenoscopy 4 weeks postseptotomy revealed a gastric lumen in continuity with the large perigastric cavity

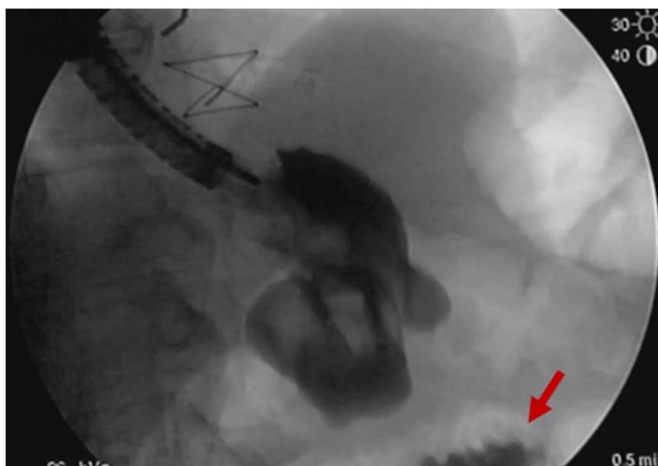


Figure 4. Fluoroscopy shows the contrast emptying from the sleeve lumen and filling the distal duodenum (red arrow).

(Figure 3). Intraprocedural contrast injection revealed 1 lumen with no demarcation with the perigastric cavity and adequate flow into the distal stomach and duodenum without holding up or tracking to distant areas outside the stomach (Figure 4).

DISCLOSURES

Author contributions: MI Itani wrote the article and approved the final article. S. Abbarh, J. Farha, and A. Kadhim wrote the article, revised the article for intellectual content, and approved the final article. V. Kumbhari edited the article, revised the article for intellectual content, approved the final article, and is the article guarantor.

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Informed consent was obtained for this case report.

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