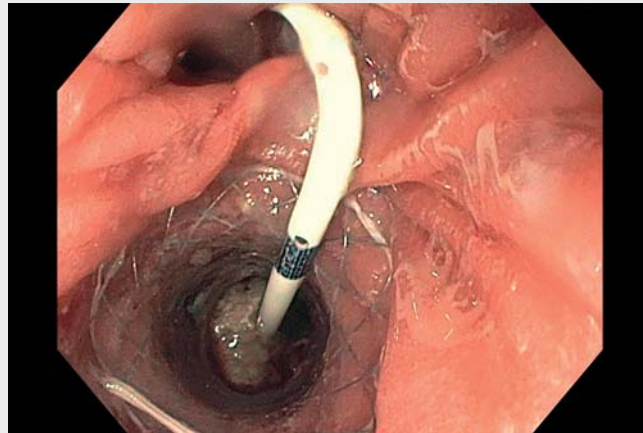


Direct retroperitoneal necrosectomy through an insufficient jejunal blind stump after gastrectomy for necrotizing pancreatitis

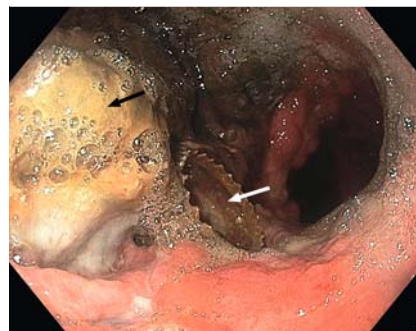
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A 53-year-old patient with a history of alcohol abuse presented with acute severe epigastric pain. Computed tomography (CT) showed signs of acute pancreatitis with a 9-cm measuring walled-off pancreatic necrosis (WOPN) in the pancreatic tail, with broad-based contact to the greater curvature of the stomach. Initial gastroscopy revealed severe ischemic gastric wall necrosis without signs of perforation (► **Fig. 1**). An electrocautery-enhanced lumen-apposing metal stent (LAMS; 15×10 mm) was implanted transgastrically under endoscopic ultrasound guidance, to enable direct necrosectomy (► **Fig. 2**). Because of a suspicion of splenic infarction, another CT scan was performed; this showed free air collections in the upper abdomen, with urgent suspicion of gastric wall perforation in the area of the ischemic gastric wall. A gastrectomy was done, with reconstruction by esophagojejunostomy and Roux-en-Y anastomosis.

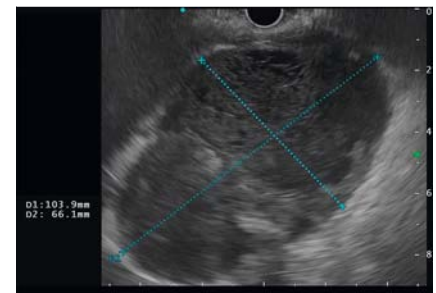
Gastroscopy 6 days postoperatively revealed an anastomotic leak at the esophagojejunostomy. Endoscopic vacuum therapy was started with changes every 3–4 days. At 16 days postoperatively, a second endoscopic vacuum sponge was inserted into a newly occurring insufficiency in the jejunal blind stump that accessed the 5-cm necrotic pancreatic cavity. At 3 weeks later, after complete healing of the esophagojejunostomy anastomosis, vacuum therapy was ended, and a LAMS (20×16 mm) was implanted in the jejunal blind stump providing access for necrosectomy of the WOPN (► **Video 1**). After five extensive endoscopic necrosectomies, the stent was removed. The patient was free of infection up to that time and was discharged from the hospital. At follow-up gastroscopy 1 week later, the jejunal blind stump had healed except for a 6-mm blind-ending fistula without secretion.



► **Video 1** Direct retroperitoneal necrosectomy through an insufficient jejunal blind stump, after gastrectomy for necrotizing pancreatitis.



► **Fig. 1** Gastroscopy after transgastric implantation of a lumen-apposing metal stent (LAMS), with the intention of draining a walled-off pancreatic necrosis collection. White arrow, distal flange of the LAMS; black arrow, severe gastric wall necrosis.



► **Fig. 2** Endosonographic ultrasound showing a 10.4×6.6-cm walled-off pancreatic necrosis (WOPN) cavity with inhomogeneous content.

Acute pancreatitis is a common disease with an unpredictable course and a wide range of severity [1,2]. This case highlights the difficulty in managing the potential complications and describes how a secondary post-surgical complication enabled an unusual approach for endoscopic treatment.

Endoscopy_UCTN_Code_TTT_1AR_2AI

Competing interests

The authors declare that they have no conflict of interest.

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Endoscopy 2022; 54: E939–E940

DOI 10.1055/a-1882-4603

ISSN 0013-726X

published online 14.7.2022

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