

Endoscopic techniques in the management of esophagojejunal dehiscence after total gastrectomy



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Anastomotic dehiscence after upper GI surgery is associated with high morbidity and mortality; however, endoscopy is often used in such treatments.¹⁻⁷ Endoscopy can provide diversion of enteral flow (stents) and drainage of sepsis (both internally and externally).

We present the case of an 80-year-old woman who initially presented with a large symptomatic paraesophageal hernia and right-sided colon cancer. She underwent laparoscopic repair of the paraesophageal hernia and concomitant right colectomy. However, she experienced an acute early herniation of the stomach into the mediastinum with gastric outlet obstruction, requiring total gastrectomy with an end-to-side esophagojejunostomy secondary to gastric ischemia.

Six days after the last operation, she had signs and symptoms of a mediastinal leak, and CT imaging showed a very large posterior mediastinal collection (Fig. 1). Endoscopy demonstrated complete dehiscence and severe sepsis (Fig. 2), which was managed with endoscopic therapy (Video 1, available online at www.VideoGIE.org).

Endoscopic treatment took 66 days and provided complete healing with spontaneous regeneration of the esophagojejunal anastomosis, collapse of the cavity, and control of sepsis (Fig. 3).



Figure 1. CT image showing large posterior mediastinal collection about 7.5 × 12 cm in diameter.

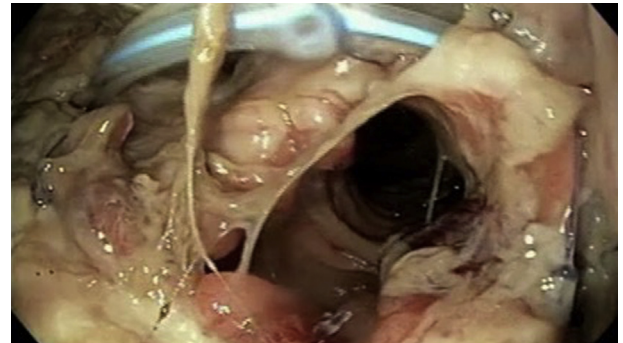


Figure 2. Endoscopic view demonstrating esophagojejunal dehiscence was 100% of the circumference with separation of the bowel ends greater than 8 cm.

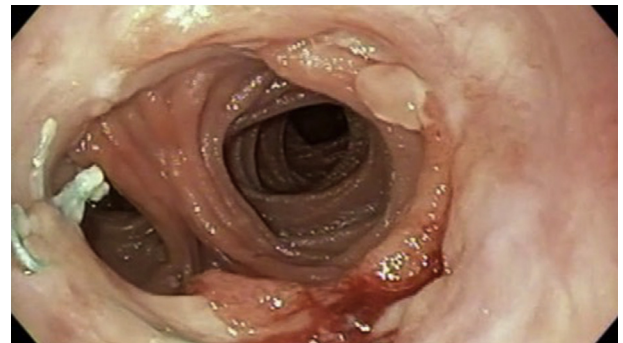


Figure 3. Endoscopic view demonstrating complete mucosal regeneration of esophagojejunal anastomosis.

DISCLOSURE

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