Endoscopic rendezvous recanalization for complete anastomotic obstruction after retrosternal coloplasty: a novel approach through a cervicotomy

A healthy 19-year-old woman previously underwent a bipolar esophageal exclusion and total gastrectomy following caustic ingestion. After 13 months, she underwent an esophageal replacement by retrosternal left colonic interposition. She subsequently developed complete obstruction of the pharyngocolonic anastomosis. Because blinded antegrade reopening of the mucosa was considered too hazardous, we considered performing a combined antegrade–retrograde endoscopic rendezvous recanalization. Owing to the prior gastrectomy and because of the retrosternal route of the coloplasty, a left cervicotomy was considered to be the best choice for the retrograde access below the anastomosis. The procedure was performed by two endoscopists and a thoracic surgeon (▶Fig. 1; ▶Video 1). The cervical colon was mobilized through a left cervicotomy, paying particular attention not to compromise its vascular pedicle. A 2-cm colotomy was performed on the tenia coli, allowing antegrade introduction of the endoscope (▶Fig. 2). The complete obstruction was identified with the two endoscopes by transillumination. Antegrade puncture using a 19-gauge needle was directed by the retrograde endoscope. After the obstruction had been successfully punctured, a Fil-guide Hydra Jagwire (0.035 inch) was introduced through the obstruction (▶Fig. 3). Dilation up to 15 mm was performed using a balloon from the antegrade side, and this was followed by insertion of a nasogastric tube to maintain the patency. The outcome was uneventful. Repeated dilations were required to achieve definitive re-sizing of the anastomosis.

Treatment of cervical anastomotic obstruction after coloplasty for caustic injury is challenging [1–3]. The endoscopic antegrade–retrograde technique appears to be an effective salvage therapy in complete anastomotic obstruction [4]. The most difficult part of the rendezvous procedure is gaining access to the colon below the anastomosis. Normally, a previous percutaneous endoscopic gastrostomy (PEG) is an easy route for the retrograde endoscopy [5]. Our case shows that a cervicotomy could be a simple option to gain access to the retrograde colon below the cervical anastomosis and avoid complex re-intervention in the abdomen.

Competing interests

The authors declare that they have no conflict of interest.

Endoscopy_UCTN_Code_TTT_1AO_2AN
The authors

Michael Baboudjian1, Mathieu Rouy1, Mohamed Gasmi2, Abel Tadrift1, Pascal Thomas1, Marc Barthet2, Xavier Benoît D’Journo1

1 Department of Thoracic Surgery, North Hospital, Aix-Marseille University, APHM, Marseille, France
2 Department of Hepatogastroenterology, North Hospital, Aix-Marseille University, APHM, Marseille, France

Corresponding author

Xavier Benoît D’Journo, MD, PhD
Department of Thoracic Surgery, North Hospital, Aix-Marseille University, APHM, Marseille, France
xavier.djourno@ap-hm.fr

References


Bibliography

DOI https://doi.org/10.1055/a-1158-8682
Published online: 2020
Endoscopy
© Georg Thieme Verlag KG
Stuttgart - New York
ISSN 0013-726X

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

Video 1 Video showing rendezvous recanalization of a completely obstructed pharyngocolonic anastomosis. A cervicotomy was performed to allow access for the retrograde endoscope, which was then used to direct antegrad puncture. After insertion of a guidewire, balloon dilation was performed, with a nasogastric tube inserted once the rendezvous had been achieved.

Fig. 2 Photograph of the left cervicotony, which allowed access to the 10-cm proximal part of the coloplasty just below the anastomosis. After careful mobilization of the cervical colon, a 2-cm colotomy was performed, so allowing antegrade introduction of a flexible endoscope.

Fig. 3 Endoscopic view of the proximal part of the disrupted esophagus showing the rendezvous between the retrograde endoscope and a catheter with a hydrophilic guidewire that had been passed through the obstructed pharyngocolonic anastomosis from the antegrade endoscope.