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.

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