Endoscopic percutaneous drainage in a COVID-19 patient with iatrogenic gastric perforation

A 60-year-old male under mechanical ventilation through endotracheal intubation due to severe COVID-19 pneumonia was treated at our intensive care unit (ICU) with extracorporeal membrane oxygenation for several weeks. Computed tomography (CT) revealed bilateral lung involvement and a left pulmonary abscess drained by a percutaneous catheter (▶Fig. 1). Percutaneous endoscopic gastrostomy (PEG) was performed, but the patient developed an early buried bumper syndrome [1–4] after one month, so the tube was removed and gastroscopy showed an unexpected gastric perforation of the fundus (▶Fig. 2, ▶Video 1), defined as de novo perforation.

A CT scan showed a fluid collection in the left upper abdominal region, so the multi-disciplinary decision was to perform a peritoneoscopy (with a 6-mm scope), which was safely performed thanks to the insufflation of carbon dioxide [5]. The ultra-slim scope allowed us to cross the gastric leak and directly visualize the diaphragm (▶Fig. 3a), spleen (▶Fig. 3b), and the inner abdominal wall defect from PEG insertion (▶Fig. 3c).

The patient was critically ill and unfit for surgery, so we placed a percutaneous drainage and closed the leak with an endoscopic suturing system. The isolated COVID-ICU room was organized as an endoscopic theater, allowing us to perform the procedure at bedside. The percutaneous drainage was inserted through the abdominal wall defect (previous PEG fistula) under direct endoscopic and radiologic visualization (▶Fig. 4a, b). Continuous sutures were performed using the OverStitch suturing device (Apollo Endosurgery, Inc., Austin, Texas, USA) (▶Video 1), and closure was confirmed by the absence of intra-abdominal contrast diffusion after intra-gastric contrast injection (▶Fig. 5).

Meanwhile, the SARS-CoV-2 infection resolved, allowing his transfer to the ICU, where a second gastroscopy was necessary due to lack of clinical improvement. It showed another leak next to the sutured area, so another suture was performed and strengthened with a whipstitch over it (▶Video 1). The absence of intra-abdominal contrast diffusion confirmed the complete closure, but he died one month later from his terminal pulmonary condition.

Endoscopy_UCTN_Code_TTT_1AO_2AI

Competing interests

The authors declare that they have no conflict of interest.
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Granata Antonino et al. Endoscopic percutaneous drainage... Endoscopy 2022; 54: E686–E688 | © 2022. Thieme. All rights reserved.
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