Novel stent to treat fistula and leak after gastric sleeve surgery

Laparoscopic sleeve gastrectomy can result in complications, which include gastric fistula (5%), and intra-abdominal locoregional collections (1%) [1]. This report describes a novel method and stent for the treatment of a leaking gastroperitoneal fistula in a patient with a gastric sleeve. A 23-year-old woman underwent a laparoscopic sleeve gastrectomy as treatment for morbid obesity. On Day 11 the patient complained of abdominal pain and fever. The computed tomography scan showed a fluid collection in the left upper quadrant. Because the endoscopic application of clips and fibrin glue did not resolve the leak, the patient underwent laparoscopic intervention for closure of the fistula. However, 10 days later she presented with a new episode of abdominal pain and fever. Her leukocyte count was elevated at 11700/μL. An upper gastrointestinal series using iodinated contrast disclosed a left subphrenic leakage from a gastroperitoneal fistula. Esophagogastrroduodenoscopy revealed a small fistulous opening (Fig. 1a). An upper gastrointestinal series showed the leak clearly (Fig. 1b).

As the intraluminal pressure is elevated in the gastric sleeve, the sleeve was dilated using a 30-mm achalasia balloon (Rigiflex; Boston Scientific Corp., Natick, Massachusetts, USA). The Hanarostent (M.I. Tech Co., Inc., Pyeongtaek, South Korea) was then placed using the Shim’s technique (Fig. 1c, d).

This stent is almost completely covered, but it has a 10-mm noncovered rim just below the covered upper part (Fig. 1e; note that a nasojejunal feeding tube was placed to provide nutritional support, as the patient was kept nil per os). This non-covered part allows tissue ingrowth in the proximal portion, fixing the stent, preventing its migration, and sealing the lumen around the stent. The stent also has a cotton string that is pulled outside the nose and taped to the patient’s cheek. This also prevents stent migration. The strings are covered by a flexible silicone tube to protect the upper airways and esophageal mucosa. After 5 days the string and silicone tube are removed. Usually, treatment with opioids is indicated, because the stent causes distension of the contracted gastric sleeve.

In the current patient, the percutaneous drain was removed 12 days later because there were no more drain secretions. After 4 weeks the stent was removed. No leaks were seen on upper gastrointestinal series (Fig. 1f). The patient was doing well 3 months later.

Competing interests: None

Fig. 1 Stent placement for treatment of a leaking gastroperitoneal fistula in a patient with a gastric sleeve. a The fistula orifice. b Radiograph showing the fistula path. c The deployed stent. d Radiograph during stent placement. e Hyperplastic tissue fixing the stent in place. f Radiograph showing the resolution of the leak.
Reference

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1377534
Endoscopy 2014; 46: E483–E484
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Marco Aurelio D’Assuncao, MD, MSc
Digestive Endoscopy Unit
Hospital Sirio Libanes
Rua Adma Jafet, 91 1°SS
Sao Paulo
SP, 01308-050
Brazil
Fax: +55-11-31553721
mada.endoscopia@hotmail.com

Marco A. D’Assuncao, Rafael M. P. Machado, Saverio T. N. Armellini, Raul Cutait, Amanda M. B. Ziegler, Danilo Daud, Daniel Moribe
1 Department of Digestive Endoscopy Unit, Hospital Sirio Libanes, Sao Paulo, Brazil
2 Department of Surgery, Hospital Sirio Libanes, Sao Paulo, Brazil