Rescue therapy with over-the-scope clip closure for a large postoperative colonic leak

A 78-year-old woman was admitted urgently with sudden-onset abdominal pain and a fever of 40 °C. A plain abdominal computed tomography (CT) scan revealed peritonitis due to perforation of diverticulitis in the descending colon. Emergency open surgery involving resection of the descending colon, creation of a transverse colostomy, and closure of the blind sigmoid colon was performed.

The patient developed abdominal pain on the left lower side on day 7, and a leak at the functional anastomotic site of the blind sigmoid was suspected on a repeat CT scan (Fig. 1). She developed disseminated intravascular coagulation, and reoperation was deemed risky. The drain used during open surgery was placed at the pouch of Douglas and the left dorsal and infradiaphragmatic sites.

Colonoscopy of the blind sigmoid colon was performed without air insufflation and the lumen was lavaged with lukewarm saline (2L). A dehiscence of the anastomotic site, approximately 15mm in diameter, was observed (Fig. 2a). Peritoneal lavage with saline (4–5L) was performed, while continuous suction was applied through the drain. The endoscope was removed after the lumen of the sigmoid colon had been relavaged with saline (2L). The OTSC was attached to the endoscope, which was inserted to the area of the dehiscence. There was no evidence of liquid stool around the mesentery after lavage (Fig. 2b).

To prevent further leakage, the OTSC was then placed as a seromuscular suture (Fig. 2c; Video 1): the mucosa of the normal anal sigmoid colon located 10mm from the margins of the dehiscence was grasped using a Twin Grasper and the mucosa around the fistula, which had a poor blood flow, was pulled back into the gut.
After closure, the sigmoid colon was dilated thoroughly via air insufflation, with no air leak from the drain being observed (Fig. 2d). After OTSC closure, the results of the patient’s blood tests and her general condition improved.

Closure using an OTSC after adequate lavage with lukewarm saline in the abdominal cavity and intestinal tract appears effective as rescue therapy for a large postoperative colonic leak.

Competing interests: None

References

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