Gastrointestinal Bleed from a Left Ventricle to Colonic Interposition Graft Fistula following an Esophagectomy

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Introduction

The use of colonic interposition grafts to reconstruct the thoracic alimentary canal is an established technique for many esophageal conditions. Contemporary mortality rates for this type of esophageal reconstruction are between 5 and 8% with morbidity rates between 55.7 and 65%.1,2 Common complications include pneumonia, arrhythmias, wound infections, anastomotic leaks, graft ischemia, and stricture.1,3 Cardiac complications are extremely rare with only one case being reported in the literature.4

Case Description

A 46-year-old female presented to the emergency department with an exacerbation of chronic left-sided chest pain and a several month history of malaise, fatigue, and weight loss. The patient’s surgical history was significant for esophageal reconstruction using a colonic interposition graft for esophageal atresia, a colonic interposition graft revision, and a strictureplasty at the cologastric junction. During her hospital course, she developed hematemesis, hematochezia, and hypotension. Computed tomography (CT) of the chest demonstrated extravasation of contrast from the left ventricle (LV) into the colonic interposition graft (►Fig. 1A). The patient was transferred to the cardiac surgery service with the diagnosis of a left ventricular–colonic interposition graft fistula. Transthoracic echocardiography demonstrated a left ventricular pseudoaneurysm (►Fig. 1B), normal left ventricular function, mild-to-moderate mitral regurgitation, and no evidence of endocarditis. Doppler echocardiography demonstrated flow within the pseudoaneurysm (►Fig. 1C), and angiography confirmed a left ventricular pseudoaneurysm (►Fig. 1D) without significant coronary artery disease.

The patient was taken to the operating room emergently. Peripheral cannulation of the left femoral artery and right femoral vein for cardiopulmonary bypass was performed. Median sternotomy and pericardial adhesiolysis were performed without incident. The left ventricular apex was adhered to the pericardium posteriorly. Cardiopulmonary bypass was...
The most significant principle illustrated is the need for a coordinated, multidisciplinary approach that is focused on the management of potentially catastrophic cardiac injuries. Ventriculocolonic fistula is an extremely rare complication of a colonic interposition graft following esophagectomy. This case has instructional value as it highlights several key principles in the management of potentially catastrophic cardiac injuries.
early aggressive resuscitation, rapid diagnosis, and emergent transfer to a cardiac surgery service. The second principle is that of a staged definitive repair. The decision to proceed with a stepwise repair was taken for several reasons. First, the significant amount of time on cardiopulmonary bypass, coupled with large transfusion and hypothermia, greatly increases the risk of morbidity and mortality. A single-stage procedure could have resulted in significant coagulopathy and possibly an increased risk of anastomotic breakdown. The primary goal of this procedure was to repair her LV and establish source control of the colonic disruption.

With regard to the cardiac repair, having a plan for peripheral cannulation was prudent. The peripheral cannulation and early cardiopulmonary bypass allow management of unforeseen complications such as free rupture and catastrophic hemorrhage. The LV was repaired in a similar fashion to a conventional ventricular rupture or chronic ventricular aneurysm. The rationale for using autologous pericardium to exclude the colonic defect was derived from the theory that it may be less prone to infection, given that it was in direct contact with the alimentary canal until definitive thoracic repair.

Delaying definitive thoracic surgical intervention has several benefits and challenges; the optimum timing for excision of the colonic interposition graft and esophageal diversion is unknown in this situation. Delayed repair does allow the patient to stabilize following the initial surgical intervention. However, there is no way to know how long it will take the patient to stabilize between operations, which may expose the patient to unanticipated complications. In an effort to save the conduit, debridement and repair of the colonic defect are attempted initially. Primary repair was not successful due to the significant contamination and subsequent tissue damage. Colonic conduit excision and esophageal diversion were ultimately required for patient safety. In conclusion, the authors would recommend definitive cardiac repair followed by staged esophageal resection and cervical esophagostomy with delayed definitive esophageal reconstruction.

References