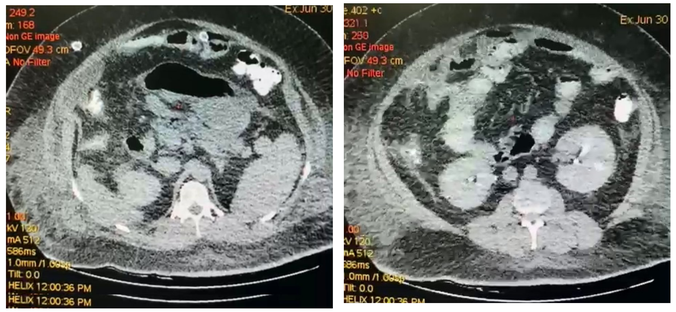
ENDOSCOPIC STENTING FOR GASTROJEJUNOSTOMY LEAK STATUS POST ROBOTIC ONE ANASTOMOSIS GASTRIC BYPASS

Shubham Bhatia, Aayushi Jain, Sushant Wadhera,
Sarfaraz Jalil Baig, Parveen Bhatia

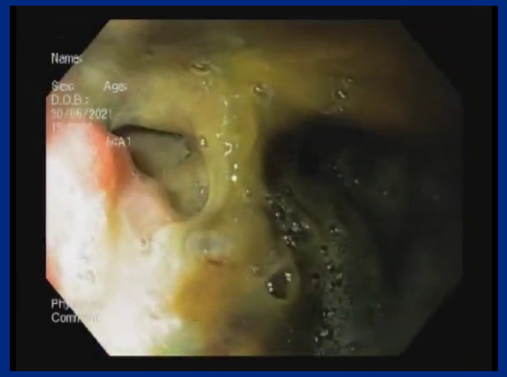
Case Presentation

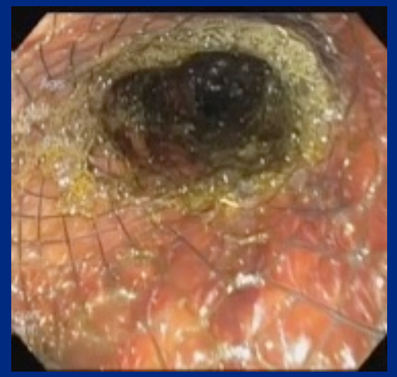
39-year-old male (BMI 48.8) presented to us on POD#9 after Robotic one anastomosis gastric bypass (OAGB) done elsewhere. Patient's records revealed tachycardia and hypotension on POD#1 with imaging revealing staple line hematoma without any leak. Patient was managed there conservatively in ICU receiving 4 units packed RBCs. Drain output ranged between 100-200ml/day until POD#8 when output increased to 1200ml and necessitated the transfer. On admission, abdomen was distended, tender and drain output was 1500ml bilious, WBC of 22000/mm3. Repeat CECT revealed air admixed localized collection along anterior aspect of stomach and tracking underneath anterior abdominal wall, extravasation of contrast from GJ anastomosis into collection and into the drain with no other pelvic collections.



Considering the delayed and septicemic presentation, a multidisciplinary decision was taken to opt for endoscopic stent placement. On POD#9, a Mega 24cm-long 26mm-wide self-expandable metallic stent (SEMS) was placed from GE Junction to GJ site extending into efferent loop under fluoroscopic guidance. An NJ tube was placed for feeding.

Anastomosis-related leak successfully managed endoscopically with a long self-expanding metallic stent as a viable option.







Subsequently, drain output decreased to 350-500ml/day. However, patient developed steatorrhea and jaundice likely from failure of bile to reach common limb from afferent loop. Drain's bilious contents were re-fed through NJ tube with resolution of steatorrhea over time. CECT on POD#15 showed stent in-situ with smaller collection around GJ without any extravasation or new collections elsewhere. Subsequently, drain output reduced to 10-20mL/day with no significant intra-abdominal collection seen. On POD#42, patient underwent repeat endoscopy showing completely healed mucosal defect and stent was removed with low-threshold to replace if needed. NJ tube replaced for feeding and removed 5 days later. Patient tolerated oral diet, weight decreased to 132kg, and was discharged without any drains, stent or NJ tube.



Discussion

Postoperative leaks after OAGB range from 1-5%. One study with 2780 patients suggests that non-surgical management is successful in as many as 72% of cases. If endoscopy and interventional radiology are available, reoperation can be avoided in most patients. Another study cites a much higher leak rate in revisional OAGB of about 4% vs. 1.3% for primary OAGB. OAGB complications are divided into anastomosis-related which resemble those of RYGB, and staple line-related resembling LSG. Anastomotic leaks controlled with stents exhibit a favorable outcome in contrast to staple line leaks. We present a case of anastomosis-related leak successfully managed endoscopically with a long self-expanding metallic stent as a viable option.

Shubham Bhatia
PGY2– General Surgery
Flushing Hospital Medical Center
shubhambhatia@gmail.com

FLUSHING HOSPITAL MEDICAL CENTER

Bhatia Global Hospital &
Endosurgery Institute
New Delhi, India