



IT TAKES A VILLAGE: MULTIDISCIPLINARY APPROACH TO RESTORATION OF LUMINAL CONTINUITY AFTER COMPLETE ESOPHAGOGASTRIC ANASTOMOTIC DEHISCENCE

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INTRODUCTION

Esophageal anastomotic leak following esophagectomy carries significant morbidity and mortality. Complete dehiscence is a rare and particularly challenging subset, as conventional endoscopic therapies such as stenting or endoluminal vacuum are often not feasible. We present a case of complete esophagogastric anastomotic dehiscence successfully managed through multidisciplinary rendezvous recanalization.

CASE PRESENTATION

A 75-year-old male with gastroesophageal junction adenocarcinoma underwent an open transhiatal esophagectomy via upper midline laparotomy with left cervical esophagogastric anastomosis. His early postoperative course was complicated by cervical anastomotic leak and complete esophagogastric anastomotic dehiscence leading to formation of a cervical esophagocutaneous fistula.

PROCEDURES

Simultaneous transoral esophagoscopy and retrograde enteroscopy via a jejunostomy tract revealed complete occlusion with a 3-cm gap between the distal cervical esophagus and proximal gastric conduit (Figure 1). Under combined endoscopic and fluoroscopic visualization, a Rosch-Uchida vascular access catheter was advanced via the esophagocutaneous fistula tract to perform sharp recanalization (Figure 2), followed by wire-guided placement of a nasoenteric Corpak tube traversing both lumens to maintain continuity (Figure 3). Over subsequent weeks, serial dilations were performed under simultaneous transoral and transjejunal endoscopic guidance, culminating in lumen-apposing metal stent (LAMS) placement to re-establish durable luminal patency (Figure 4).

STEP 1

Figure 1. Fluoroscopic view of aligned transoral gastroscope and transjejunal enteroscope tips revealing a 3-cm separation between the proximal cervical esophagus and distal gastric conduit.



STEP 2



Figure 2. Sharp recanalization under (a,b) endoscopic and (c) fluoroscopic guidance using a Rosch-Uchida catheter advanced via the esophagocutaneous fistula tract into the gastric conduit.

STEP 3

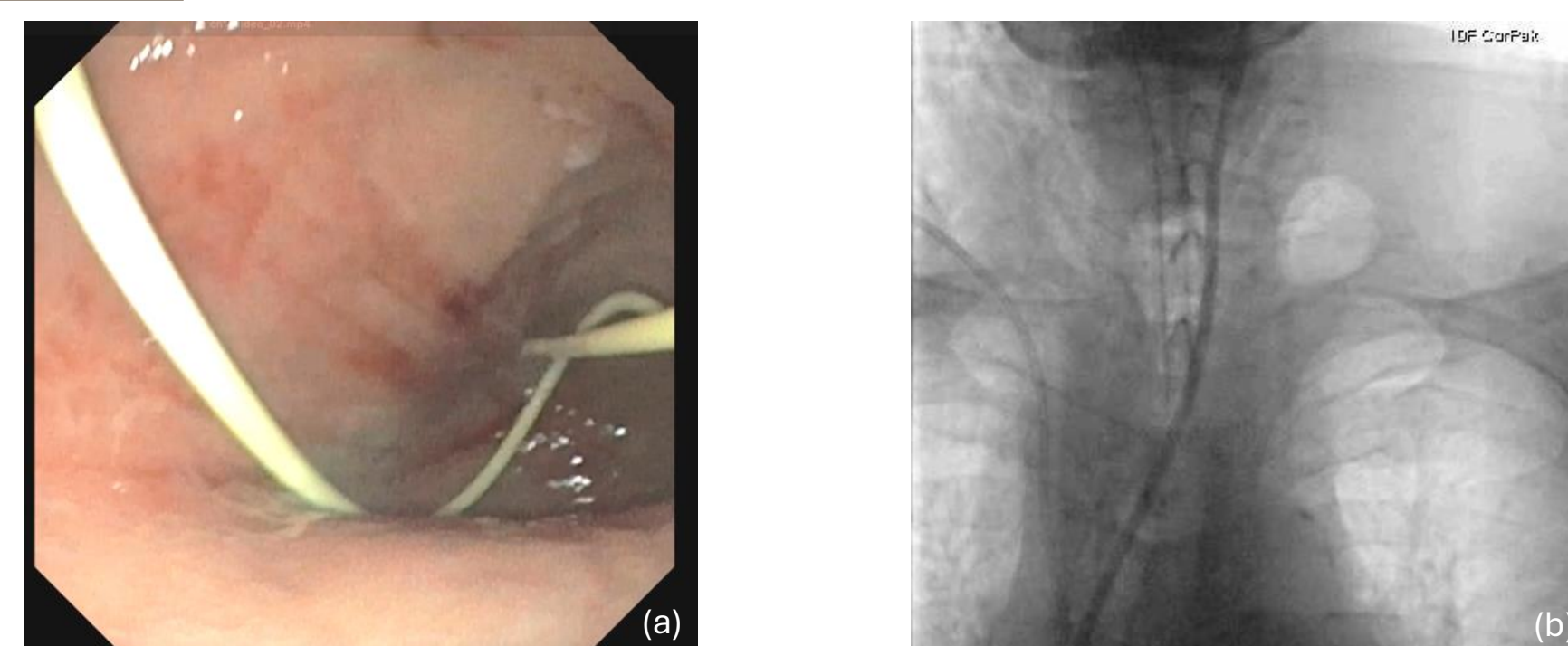


Figure 3. Wire-guided placement of a Corpak tube across the recanalized esophagogastric segment under (a) endoscopic and (b) fluoroscopic guidance.

STEP 4

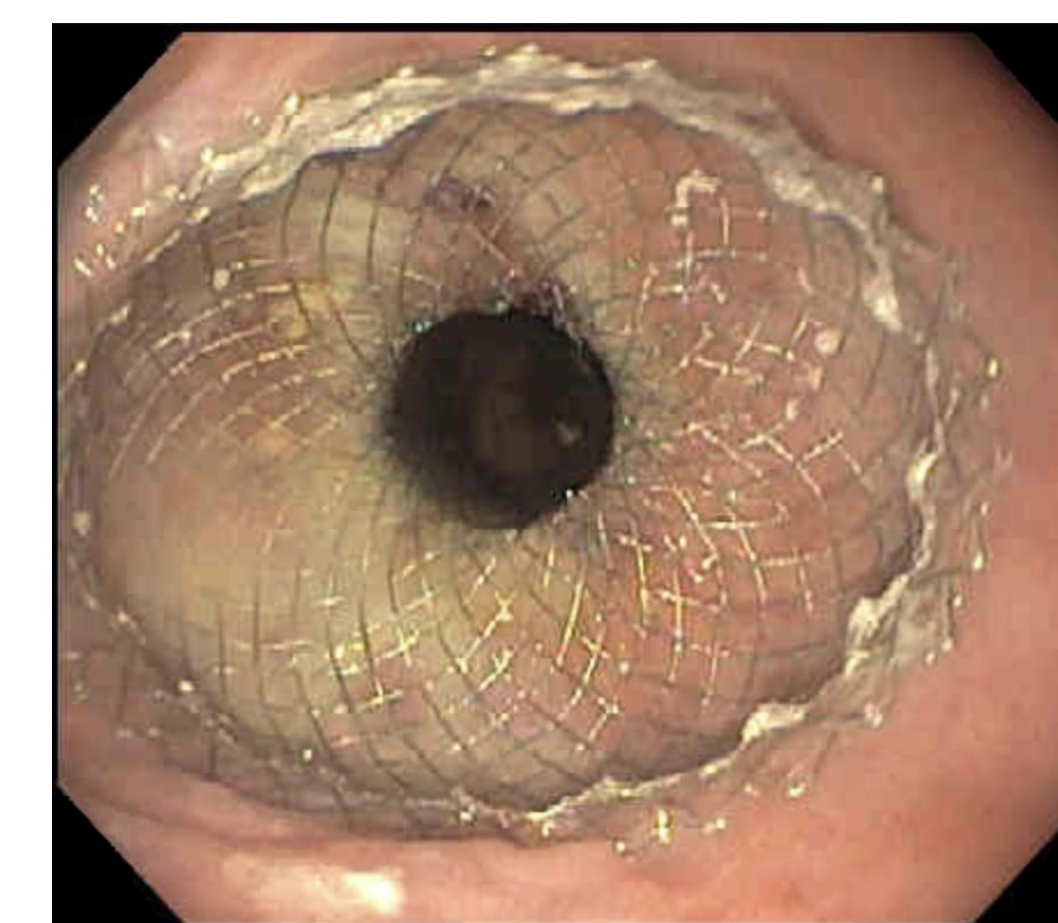


Figure 4. Endoscopic view of a 20 mm x 10 mm lumen-apposing metal stent deployed across a high-grade stricture at the re-established esophagogastric anastomosis to maintain luminal patency.

RESULTS

Initial rendezvous recanalization successfully restored luminal continuity across a completely occluded esophagogastric anastomosis. Despite development of high-grade restenosis, repeat recanalization and serial dilations followed by LAMS placement resulted in sustained luminal patency. The patient ultimately tolerated oral intake, maintained body weight, and discontinued jejunostomy tube feeds.

CONCLUSIONS

Complete esophagogastric anastomotic dehiscence is a rare complication lacking standardized management strategies. This case demonstrates the feasibility of a multidisciplinary rendezvous recanalization approach when conventional endoscopic techniques are not possible. Close collaboration between thoracic surgery, advanced surgical endoscopy, and interventional radiology was critical to restoring alimentary continuity and avoiding reoperation.