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ARGOMENTO: Comunicazioni libere

TITOLO DEL LAVORO: **Bowel occlusion by esophageal stent migration after sleeve gastrectomy leak**

AUTORI

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RELATORE

INTRODUZIONE

Gastric leak still represents the most concerning and serious complication of sleeve gastrectomy. The leak rate ranges from 1 to 5% (2).
Management of gastric leak after sleeve gastrectomy is still complex and poorly standardized . Several different treatment strategies have been described for the management of staple line leaks following sleeve gastrectomy. These include surgery with a laparoscopic approach for re-suturing and drainage, endoscopic approach with different types of stenting or clips or internal drainages and conservative management .

METODI

We report a case of gastric leak after sleeve gastrectomy successfully treated with self-expandable covered stent but furtherly complicated by migration of the stent.

RISULTATI

A 41 years old woman , 42 kg/m2 BMI, underwent sleeve gastrectomy. The patient was discharged five days after surgery. Postoperative Rx with oral gastrografin was negative. One month later a staple-line leak was diagnosed. The patient was admitted to Emergency department complaining fever and abdominal pain. Blood exams revealed leucocytosis and high level of CRP. Abdomen CT scan with oral gastrografin intake documented a proximal gastric leak of the sleeve with a subphrenic abscess.
A laparoscopy with drainage of the subphrenic abscess and cleaning of the abdomen was performed. The patient stayed for 5 days in Intensive Care Unit (ICU) for a sepsis management.Total parenteral nutrition and broad-spectrum antibiotic therapy were administered. Ten days after a CT scan still releaved a gastric leak, with spillage of contrast just below the esophago-gastric junction. An esophageal fully covered stent 24 x 200 mm (Taewoong Niti-S Esophageal stent) was placed after intravenous sedation. The patient resumed oral refeeding and was discharged eight days after.
One month later the woman was admitted for abdominal distension and vomiting with respiratory distress by ab ingestis pneumonia. Gastroscopy documented lack of the stent in the gastric sleeve and several superficial ulcers of the gastric mucosal layer. A new CT scan showed stent migration in the distal ileum just before the ileo-cecal valve with diffuse jejuno-ileal dilatation.
The patient underwent minilaparotomy, enterotomy on the distal ileum, removal of the stent and suture of the enterotomy. After adhesiolisis intraoperative exploration of the esophago-gastric junction with methylene blue test did not yet reveal any gastric leak nor spillage. Postoperatively the patient stayed in ICU for five days with recovery of respiratory function and then returned to the surgical ward. The following course was uneventful and the patient was discharged in stable condition with a progressive oral refeeding.

DISCUSSIONE

Gastric leak management after sleeve gastrectomy still remains challenging and difficult to perform. Standard protocols of gastric leak treatment still lack. So success rate of treatment is based on the multidisciplinary approach to the patient and the correct evaluation of the fistula both endoscopically and radiologically.
As mentioned in this case report placement of an esophageal stent resulted in healing of the gastric leak but unfortunately was complicated by a troublesome migration with

bowel occlusion requiring a further surgical procedure.

BIBLIOGRAFIA

Revisore	Non assegnato
Accettazione	Non ancora definito
Note	