

BRIEF REPORT

OUTPATIENT STENTING OF POST SLEEVE GASTRECTOMY LEAKS

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Methods

Between January and June 2022, 2 patients, a 34- year-old-man and a 22 year-old- woman, presented, one month and 4 months respectively, following laparoscopic sleeve gastrectomy, a type II (1) gastric leak documented on CT scan. The 2 patients were directly addressed for endoscopic internal drainage of the leak. The orifice of the leak was identified under the gastroesophageal junction and catheterized, under endoscopic guidance by a guidewire, followed by the introduction of a 7Fr,7 cm plastic pancreatic endoprosthesis (Geenen pancreatic stent, Cook, Limerick) in the anomalous tract. (Figure 1) Patients were discharged directly after the procedure. Oral antibiotic was prescribed as well as early soft oral alimentation.

Results

At follow-up, 10 days and one month later, the patients were asymptomatic, eating normally and had a normal CRP. Resolution of the paragastric abscess as well as the absence of extravasation of the oral contrast were documented on the CT Scan done at 4 months in the first case (Figure 2) and at 2 months in the second one. Endoprosthesis was then, easily removed with a snare. One month later, after the removal of the stent, the patients were still doing well.

Conclusion

Gastric leak post laparoscopic sleeve gastrectomy is reported in 1.5-3% of cases and occur most commonly at the gastroesophageal junction. (2) Management of subacute and chronic leaks with endoscopic internal drainage by means of a biliary or pancreatic plastic stent was already described by our team. (3) We moved lately to simplify our technique and to reduce costs. Patients were treated in our endoscopy unit as an outpatient, placement of the plastic stent was performed under endoscopic control after identification of the luminal orifice of the leak, without fluoroscopic guidance and we were feeling confident to start early soft oral feeding.

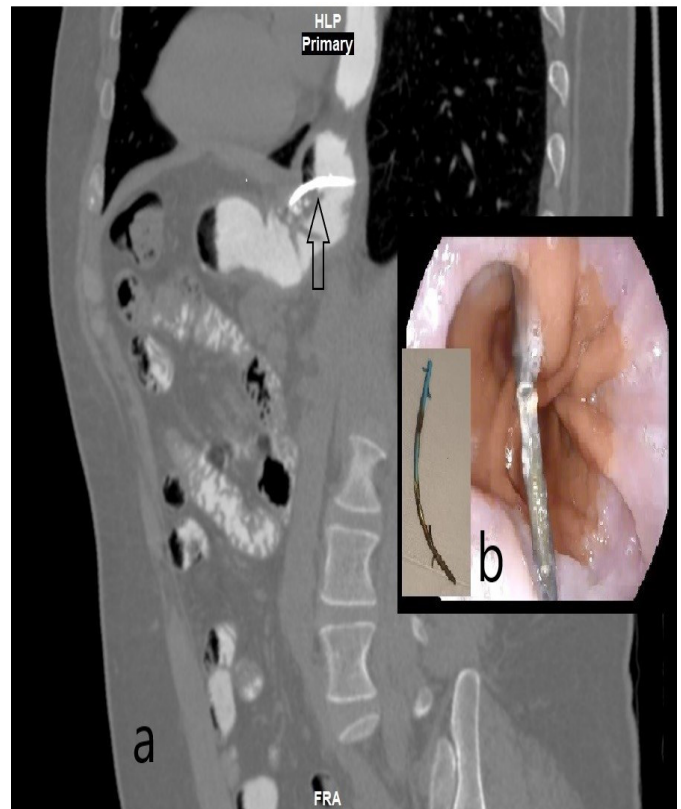


Figure 2: Contrast enhanced abdomino-pelvic multidetector-row computed tomography (MDCT) (a) showing the distal end of the endoprosthesis (arrow) in the peri-gastric area with no extravasation of the oral contrast and the proximal end partially migrated in the oesophageal lumen, With the corresponding aspect of the endoprosthesis on upper endoscopy before it was removed (b).

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