Rendezvous recanalization of a postoperative coloanal anastomotic dehiscence with a lumen-apposing metal stent

► **Fig. 1** Fluoroscopic image showing the rendezvous approach.

► **Fig. 2** Endoscopic view showing proper deployment of the stent across the dehiscence.

► **Fig. 3** Fluoroscopic image showing the lumen-apposing metal stent in situ.

► **Fig. 4** Endoscopic view showing the patent anastomosis after stent removal.

► **Video 1** The video shows the rendezvous approach being used to recanalize a coloanal anastomotic dehiscence with a lumen-apposing metal stent.

LAMs have been successfully used for the recanalization of complete colorectal anastomotic obstructions [1, 2]. However, there are no reports of using LAMs in the treatment of coloanal anastomotic dehiscence.

A 51-year-old man with a rectosigmoid tumor underwent low anterior resection. His surgery was then complicated by leakage, which was treated by proctectomy, coloanal anastomosis, and creation of a diverting ileostomy. On follow-up sigmoidoscopy, the anastomosis appeared to have dehiscenced and no lumen to the proximal colon was identified. Therefore, a rendezvous approach was planned for the treatment of coloanal anastomotic dehiscence.

An upper gastrointestinal (GI) endoscope was advanced transanally to the coloanal anastomosis, while a pediatric colonoscope was advanced towards the anastomosis through the loop ileostomy (► **Fig. 1**). With the use of fluoroscopic guidance and transillumination, the dehiscenced coloanal anastomosis was identified. A guidewire was advanced in an antegrade direction and was captured from the anus. A 15×10-mm LAMS was then inserted over the wire from the

anal side and successfully deployed across the anastomosis (► **Fig. 2** and ► **Fig. 3**; ► **Video 1**).

The patient was discharged home in good condition 1 day after the procedure. After 2 months, a flexible sigmoidoscopy was carried out, in which the stent was removed with a forceps. The upper GI endoscope was advanced to a point proximal to the anastomosis, which was noted to be widely patent (► **Fig. 4**). The stent was then reloaded into the therapeutic upper

GI endoscope and redeployed across the anastomosis to ensure the area remained patent. After 4 months, the stent was removed following ileostomy reversal. The patient continues to do well after 3 months of follow-up.

In conclusion, treatment of postoperative coloanal anastomotic dehiscence using a LAMS placed via the rendezvous technique is feasible and effective.

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Competing interests

Mouen A. Khashab is a consultant and on the medical advisory board for Boston Scientific and Olympus. The remaining authors have nothing to disclose.

The authors

Omid Sanaei, Olaya Brewer Gutierrez, Robert Moran, Juliana Yang, Mouen A. Khashab
Division of Gastroenterology and Hepatology,
Johns Hopkins Medical Institutions, Baltimore,
Maryland, USA

Corresponding author

Mouen A. Khashab, MD

Johns Hopkins Hospital, 1800 Orleans Street,
Sheikh Zayed Tower, Baltimore, MD 21287,
USA

Phone: +1-443-287-1960
mkhasha1@jhmi.edu

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CORRECTION

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In the above mentioned article the page numbers have been corrected.

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