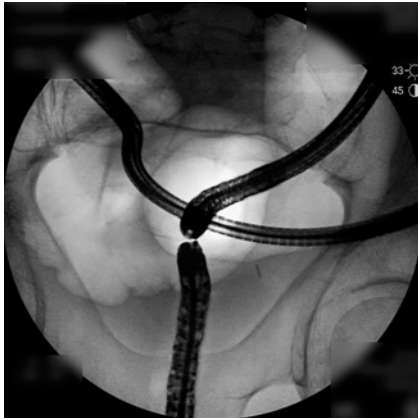
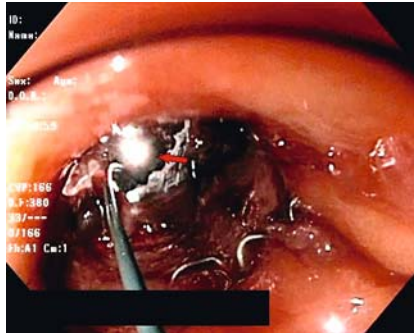


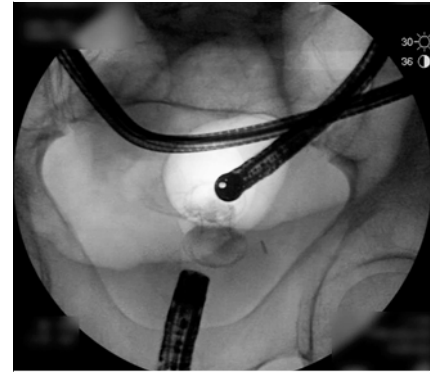
Rendezvous recanalization of a postoperative coloanal anastomotic dehiscence with a lumen-apposing metal stent



► **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 dehisced 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 dehiscent 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.

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