Successful closure of a gastropulmonary fistula after esophagectomy using the Apollo Overstitch and endoscopic vacuum therapy

Gastropulmonary fistulas following transthoracic en bloc esophagectomy and intrathoracic gastric reconstruction (Ivor Lewis esophagectomy) are rare but life-threatening complications. Surgical management of these is difficult and associated with significant instances of morbidity and mortality [1]. One possible treatment for leaks after upper gastrointestinal surgery is endoluminal vacuum therapy (EVT) [2]. A newer treatment option is the endoscopic suturing system Apollo Overstitch [3–5]. The Overstitch is a single-use device that is placed on top of a double-channel therapeutic endoscope, which facilitates full-thickness surgical suturing in single or running technique. To our knowledge, the case presented below constitutes the first successful clinical application of a combination of Overstitch and EVT to close a gastropulmonary fistula after Ivor Lewis esophagectomy.

We present the case of a 58-year-old man who underwent neoadjuvant chemoradiation (histopathology: ypT3, ypN2 (3/45), L1, V0, Pn0, R0). About 3 months after the initial surgery, the patient was admitted to our hospital with recurring episodes of pneumonia. Computed tomography (CT) scanning with oral contrast and endoscopy showed a fistula between the pull-up gastric interponate and the right lung parenchyma (▶Fig. 1 and ▶Fig. 2). We applied the Overstitch system to close the fistula endoscopically. After two attempts, we were able to close the fistula using the single-suturing technique (▶Fig. 3; ▶Video 1). A triple-lumen diverted nasal tube (e.g. Freka Trelumina; Fresenius Kabi, Germany) was then inserted to allow the patient to receive enteral feeding. Furthermore, to evacuate any biliary reflux and reduce the pressure on the suturing line, we placed a polyurethane foam drainage tube (e.g. EsoSponge; Braun, Germany) with negative pressure (–125 mmHg, continuous; VivanoTec; Hartmann AG, Germany). During the 31 days of this EVT, the foam drainage was changed seven times. 

Gastropulmonary fistulas following transthoracic en bloc esophagectomy and intrathoracic gastric reconstruction (Ivor Lewis esophagectomy) are rare but life-threatening complications. Surgical management of these is difficult and associated with significant instances of morbidity and mortality [1]. One possible treatment for leaks after upper gastrointestinal surgery is endoluminal vacuum therapy (EVT) [2]. A newer treatment option is the endoscopic suturing system Apollo Overstitch [3–5]. The Overstitch is a single-use device that is placed on top of a double-channel therapeutic endoscope, which facilitates full-thickness surgical suturing in single or running technique. To our knowledge, the case presented below constitutes the first successful clinical application of a combination of Overstitch and EVT to close a gastropulmonary fistula after Ivor Lewis esophagectomy.

We present the case of a 58-year-old man who underwent neoadjuvant chemoradiation (histopathology: ypT3, ypN2 (3/45), L1, V0, Pn0, R0). About 3 months after the initial surgery, the patient was admitted to our hospital with recurring episodes of pneumonia. Computed tomography (CT) scanning with oral contrast and endoscopy showed a fistula between the pull-up gastric interponate and the right lung parenchyma (▶Fig. 1 and ▶Fig. 2). We applied the Overstitch system to close the fistula endoscopically. After two attempts, we were able to close the fistula using the single-suturing technique (▶Fig. 3; ▶Video 1). A triple-lumen diverted nasal tube (e.g. Freka Trelumina; Fresenius Kabi, Germany) was then inserted to allow the patient to receive enteral feeding. Furthermore, to evacuate any biliary reflux and reduce the pressure on the suturing line, we placed a polyurethane foam drainage tube (e.g. EsoSponge; Braun, Germany) with negative pressure (–125 mmHg, continuous; VivanoTec; Hartmann AG, Germany). During the 31 days of this EVT, the foam drainage was changed seven times.

Gastropulmonary fistulas following transthoracic en bloc esophagectomy and intrathoracic gastric reconstruction (Ivor Lewis esophagectomy) are rare but life-threatening complications. Surgical management of these is difficult and associated with significant instances of morbidity and mortality [1]. One possible treatment for leaks after upper gastrointestinal surgery is endoluminal vacuum therapy (EVT) [2]. A newer treatment option is the endoscopic suturing system Apollo Overstitch [3–5]. The Overstitch is a single-use device that is placed on top of a double-channel therapeutic endoscope, which facilitates full-thickness surgical suturing in single or running technique. To our knowledge, the case presented below constitutes the first successful clinical application of a combination of Overstitch and EVT to close a gastropulmonary fistula after Ivor Lewis esophagectomy.

We present the case of a 58-year-old man who underwent neoadjuvant chemoradiation (histopathology: ypT3, ypN2 (3/45), L1, V0, Pn0, R0). About 3 months after the initial surgery, the patient was admitted to our hospital with recurring episodes of pneumonia. Computed tomography (CT) scanning with oral contrast and endoscopy showed a fistula between the pull-up gastric interponate and the right lung parenchyma (▶Fig. 1 and ▶Fig. 2). We applied the Overstitch system to close the fistula endoscopically. After two attempts, we were able to close the fistula using the single-suturing technique (▶Fig. 3; ▶Video 1). A triple-lumen diverted nasal tube (e.g. Freka Trelumina; Fresenius Kabi, Germany) was then inserted to allow the patient to receive enteral feeding. Furthermore, to evacuate any biliary reflux and reduce the pressure on the suturing line, we placed a polyurethane foam drainage tube (e.g. EsoSponge; Braun, Germany) with negative pressure (–125 mmHg, continuous; VivanoTec; Hartmann AG, Germany). During the 31 days of this EVT, the foam drainage was changed seven times.
The patient’s infection parameters decreased with this treatment, and a follow-up endoscopy (day 34 after surgery) showed successful closure of the fistula.

Competing interests
None

The authors
Seung-Hun Chon1, Ulrich Toex2, Patrick Sven Plum1, Claudia Fuchs1, Robert Kleinert1, Christiane Bruns1, Tobias Goeser2
1 Department of General, Visceral and Cancer Surgery, University Hospital of Cologne, Kerpener Str. 62, 50937 Cologne, Germany
2 Department of Gastroenterology and Hepatology, University Hospital of Cologne, Germany

Corresponding author
Seung-Hun Chon, MD
General, Visceral and Cancer Surgery, University Hospital of Cologne, Kerpener Str. 62, 50937 Cologne, Germany
Fax: +49-221-47886227
seung-hun.chon@uk-koeln.de

References

DOI https://doi.org/10.1055/a-0592-6384
Published online: 13.4.2018
Endoscopy 2018; 50: E149 – E150
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Endoscopy E-Videos
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

This document was downloaded for personal use only. Unauthorized distribution is strictly prohibited.