Endoscopic incision and balloon dilation using the rendezvous technique for complete anastomotic obstruction after rectal low-anterior resection

Anastomotic stenosis, a major complication after low-anterior resection, can usually be treated by endoscopic balloon dilation [1,2]. However, endoscopic management is challenging in the presence of a complete obstruction because an endoscope and other devices cannot be passed through the obstruction. Combined endoscopic incision and balloon dilation has reportedly been useful for treating complete rectal anastomotic obstruction [3]. If the patient has a stoma with double orifices, a simultaneous antegrade–retrograde approach to the obstructed anastomosis using two endoscopes may be feasible, a method known as the “rendezvous technique” [4].

A woman in her 60s underwent laparoscopic rectal low-anterior resection and a diverting loop ileostomy after previous endoscopic submucosal dissection (ESD) for early rectal cancer. Stoma closure was scheduled to be performed 7 months post-surgery, but a colonoscopy performed for preoperative evaluation revealed complete obstruction of the rectal anastomosis (Fig. 1). Accordingly, endoscopic intervention was attempted for this obstruction.

An endoscope (PCF-H290Ti; Olympus Co., Tokyo, Japan) with a distal attachment (D-201-11804; Olympus) was passed through the distal loop ileostomy site and the other inserted transanally, to approach the obstruction site, with no evidence of flow of contrast agent sprayed from the trans-stomal endoscope to the anorectal side (Fig. 2). Transillumination from the trans-stomal endoscope could be seen across the septum (Fig. 3), suggesting that the obstruction was membranous.

The obstruction site was incised from the anal side (Fig. 4), while the endoscopist on the right confirms the incision site from the oral side. Complete recanalization of the obstruction following endoscopic balloon dilation was achieved (Fig. 5).
side using an electrosurgical endoknife (ISSEN; Kaneka Co., Tokyo, Japan) while the incision site was confirmed from the oral side using the rendezvous technique (▶ Fig. 4). After a small aperture was created, a controlled radial expansion balloon (Boston Scientific, Marlborough, Massachusetts, USA) was inserted and endoscopic balloon dilation was performed. The obstruction was completely recanalized without adverse events (▶ Fig. 5; ▶ Video 1).

Competing interests

Yoji Takeuchi received honoria from Olympus.

Acknowledgments

We thank Angela Morben, DVM, ELS, from Edanz Group (https://en-author-services.edanzgroup.com/ac), for editing a draft of this manuscript.

Corresponding author

Satoki Shichijo, MD, PhD
Department of Gastrointestinal Oncology,
Osaka International Cancer Institute, 3-1-69, Otemae, Chuo-ku, Osaka 541-8567, Japan
7satoki@oici.jp

References


Bibliography

Endoscopy 2022; 54: E90–E91
DOI 10.1055/a-1393-5165
ISSN 0013-726X
published online 15.3.2021
© 2021. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is an open 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. Processing charges apply (currently EUR 375), discounts and waivers acc. to HINARI are available.

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