Direct retroperitoneal necrosectomy through an insufficient jejunal blind stump after gastrectomy for necrotizing pancreatitis

A 53-year-old patient with a history of alcohol abuse presented with acute severe epigastric pain. Computed tomography (CT) showed signs of acute pancreatitis with a 9-cm measuring walled-off pancreatic necrosis (WOPN) in the pancreatic tail, with broad-based contact to the greater curvature of the stomach. Initial gastroscopy revealed severe ischemic gastric wall necrosis without signs of perforation (Fig. 1). An electrocautery-enhanced lumen-apposing metal stent (LAMS; 15×10 mm) was implanted transgastrically under endoscopic ultrasound guidance, to enable direct necrosectomy (Fig. 2). Because of a suspicion of splenic infarction, another CT scan was performed; this showed free air collections in the upper abdomen, with urgent suspicion of gastric wall perforation in the area of the ischemic gastric wall. A gastrectomy was done, with reconstruction by esophagojejunostomy and Roux-en-Y anastomosis.

Gastroscopy 6 days postoperatively revealed an anastomotic leak at the esophagojejunostomy. Endoscopic vacuum therapy was started with changes every 3–4 days. At 16 days postoperatively, a second endoscopic vacuum sponge was inserted into a newly occurring insufficiency in the jejunal blind stump that accessed the 5-cm necrotic pancreatic cavity. At 3 weeks later, after complete healing of the esophagojejunostomy anastomosis, vacuum therapy was ended, and a LAMS (20×16 mm) was implanted in the jejunal blind stump providing access for necrosectomy of the WOPN (Video 1). After five extensive endoscopic necrosectomies, the stent was removed. The patient was free of infection up to that time and was discharged from the hospital. At follow-up gastroscopy 1 week later, the jejunal blind stump had healed except for a 6-mm blind-ending fistula without secretion.

Acute pancreatitis is a common disease with an unpredictable course and a wide range of severity [1, 2]. This case highlights the difficulty in managing the potential complications and describes how a secondary post-surgical complication enabled an unusual approach for endoscopic treatment.

Competing interests

The authors declare that they have no conflict of interest.
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