Endoscopic negative-pressure therapy for duodenal leakage using new open-pore film and polyurethane foam drains with the pull-through technique

Few reports have described the use of endoscopic vacuum therapy (EVT) for duodenal defects [1–4]. We treated a complicated duodenal leak with EVT using the pull-through technique with a new type of open-pore polyurethane-foam drain (OPD) [5] and a novel type of open-pore film drain (OFD).

Construction of an OFD is shown in Video 1. First the distal ends of two drainage tubes (Ventrol; 12–18 Fr × 120 cm; Covidien, Argyle, Ireland) are connected. This coupling segment is then wrapped with open-pore polyurethane-foam or a very thin double-layered film (Suprasorb CNP drainage film; Lohmann & Rauscher, Germany) (Fig. 1). The diameter of the OPD is 1.5–3 cm and of the small-bore OFD is 4–6 mm (Fig. 2). Both drain types can be placed by the pull-through technique along an intestinal–cutaneous fistula. The oral end is passed out nasally and a vacuum is applied to drain the intraluminal secretions; the distal end is passed out cutaneously (Fig. 3).

We report a 53-year-old patient who presented for endoscopic examination with a persisting duodenocutaneous fistula after a very complicated course including multiple operations. Duodenal secretions were running along an intrabdominal drain placed next to the duodenum and a 2-cm transmural defect of the duodenal wall was found near to the papilla of Vater. The operative drain could be seen through this defect.

An OPD was inserted using the pull-through technique following the course of the operative drain. The foam was pulled into the internal opening of the duodenal fistula. Application of negative pressure with an electronic vacuum device (KCI Activac; setting 125 mmHg, continuous, intensity high) resulted simultaneously in closure of the defect around the tube, collapse of the duodenal lumen, and internal drainage of duodenal secretions. The drainage of secretions cutaneously stopped immediately.
On day 4, the OPD was replaced, before being changed to a small-bore OFD on day 8, which was again replaced on day 11. The size of the opening of the defect shrunk to a small fistula. EVT was continued for 14 days in total, and the OFD was then removed. Follow-up endoscopies 1 month and 3 months after the end of therapy revealed complete healing (Fig. 4).

Competing interests

Gunnar Loske is a consultant for Lohmann & Rauscher GmbH & Co. KG. The other authors have no conflict of interest to declare.

The Authors

Gunnar Loske1, Marc Liekde2, Erik Schlörcke2, Thomas Herrmann3, Frank Rucktaeschel3
1 Department for General, Abdominal, Thoracic and Vascular Surgery, Katholisches Marienkrankenhaus Hamburg gGmbH, Hamburg, Germany
2 Department for Abdominal, Thoracic and Vascular Surgery, Westküstenklinikum Heide, Heide, Germany
3 Department for Internal Medicine, Gastroenterology, Hemato-Oncology, Nephrology and Endocrinology, Westküstenklinikum Heide, Heide, Germany

Corresponding author

Gunnar Loske, MD
Department for General, Abdominal, Thoracic and Vascular Surgery, Katholisches Marienkrankenhaus Hamburg gGmbH, Alfredstrasse 9, 22087 Hamburg, Germany
Fax: +49-40-25461400
loske.chir@marienkrankenhaus.org

References

Fig. 4 Endoscopic views showing complete healing of the duodenal defect: a 28 days after the end of therapy; b 3 months after the end of therapy. Sc, scar; dl, duodenal lumen.