

CASE REPORT

Gastroscopy performed with a single-use gastroscope

INTRACAVITARY ENPT



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PATIENT HISTORY

A 57-year-old man was operated on for morbid obesity WHO grade III (BMI 43 Kg/m²) by laparoscopic gastric sleeve reduction in a referral hospital. After developing septic parameters and intra-abdominal fluid retentions postoperatively on day two, a CT scan indicated abnormality in the position of the corpus ventriculi.

Due to lack of endoscopic treatment options at the referral hospital, the patient was subsequently transferred to our centre. The patient was seriously ill according to septic clinical and laboratory parameters. He required invasive ventilation and developed a kidney failure caused by the systemic inflammatory response.

At the time of admission, a diverging suture of at least 2.5cm was seen endoscopically in the corpus. No abnormal cavity was present. We started an endoluminal endoscopic negative pressure therapy (ENPT) with a so called open-pore film drainage (OFD) using an enteral feeding tube. Simultaneously the patient was re-operated with lavage and placement of drainage tubes close to the gastric sleeve.

Endoscopic changes of the OFD were performed twice after the primary intervention. The procedure described here was performed 19 days after the primary endoscopic and surgical interventions. The patient had already been treated at the intermediate care unit. Laboratory parameters had been normalized and the kidney and lung failures had receded, but new conspicuous secretion was seen in the abdominal drainages. Due to the obesity and general state of the patient, endoscopy was performed under general anaesthesia and with endotracheal intubation.

PROCEDURE

The endoscopic intervention described in this document was the fourth procedure performed with the new aScope Gastro to date in our unit.

After the removal of the OFD, the gastroscopy was performed. Oral and esophageal passage were performed without discovering any abnormalities. A clear issue was, however, identified in the inadequate position of the former diverging suture (Images 1 + 2) in the para-gastric cavity.

Moderate fibrin coatings were seen in the 3x3 cm cavity; no fistula was founded. In addition, there was a sleeve stenosis in the middle part of the corpus distal. No abnormalities were found in the antrum or in the duodenum.

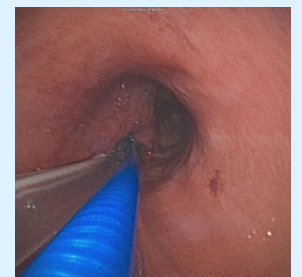


Image 1: Intracavitary placement of Eso-Sponge with an endoscopic forceps



Image 2: Endoscopic final control of the complete intracavitary placed Eso-Sponge

We changed the treatment concept from an endoluminal to an intracavitary ENPT by using the Eso-SPONGE system (B. Braun Melsungen AG, Melsungen, Germany). The sponge was placed using the loop technique, in which a loop (Mersilene, Polyester, 4 Ph. Eur; Ethicon, Norderstedt, Germany) is fixed at the distal end of the drainage sponge, gripped with an endoscopic grasper, then placed under endoscopic view (Images 3 + 4). Endoscopic placement took place via oral intubation of the esophagus, with subsequent oronasal redirection and fixation with plasters.

OUTCOME

The patient has already been discharged. Sponge changing procedures took place two times after the intervention.

CONCLUSION

The procedure described in this document was performed solely with the aScope Gastro. Visualization, lavage and suction, handling with the grasper and the sponge, and the pushing manoeuvres for sponge placement functioned without any limitations.

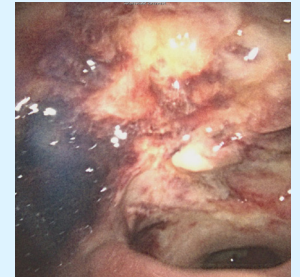


Image 3: Endoscopic view on the perigastric perforation cave

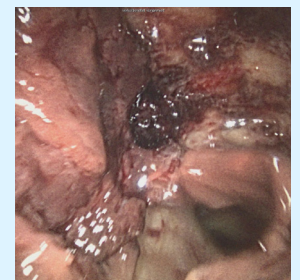


Image 4: Endoscopic view on the perigastric perforation cave

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