VIDEOGIE

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Septotomy: an adjunct endoscopic treatment for post–sleeve gastrectomy fistulas

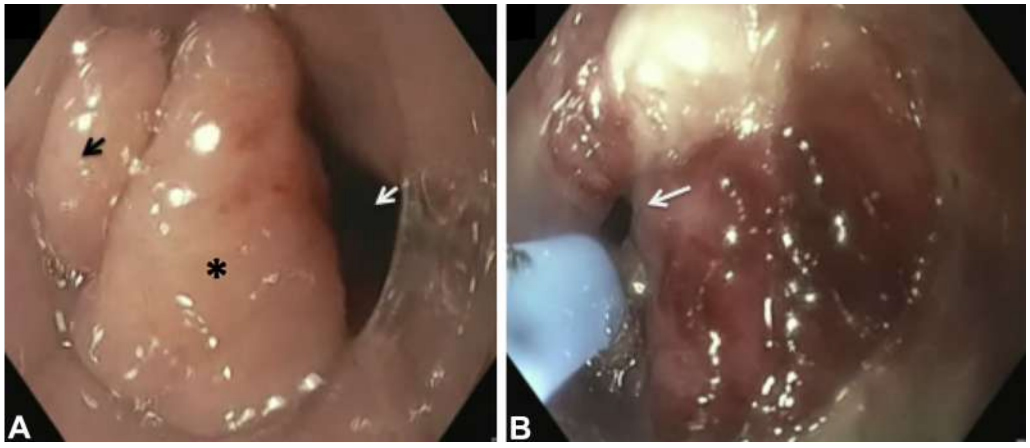

Figure 1. Endoscopic views of the gastrocutaneous fistula. **A,** A septum *(asterisk)* was dividing the gastric lumen *(white arrow)* from a pouchlike cavity *(black arrow)* conditioned by the fistula. **B,** After septotomy, the 2 lumens were communicated, and there was a complete exposition of the fistula's internal orifice *(arrow)*.

A 48-year-old woman presented with progressive abdominal pain 2 weeks after she had undergone laparoscopic sleeve gastrectomy (SG). A CT scan of the abdomen demonstrated postsurgical changes related to SG and a large extraluminal collection containing fluid, debris, and air adjacent to the surgical staple line. A percutaneous drain was placed, and endoscopic closure of the defect was attempted. Endoscopy revealed a fistulous opening adjacent to normal gastric lumen. The internal orifice of the gastrocutaneous (GC) fistula conditioned a pouch-like lumen, which was divided from the gastric lumen by a 15-mm-long septum (Fig. 1A). Septotomy was performed with argon plasma coagulation (40W) (ERBE, Tubingen, Germany) and resulted in communication of the 2 lumens (Fig. 1B). The edges of the fistula were ablated with argon plasma coagulation and the defect was closed with an over-the-scope clip (Video 1, available online at www.giejournal.org). Immediate injection of contrast medium into the gastric lumen demonstrated complete closure of the fistula (Fig. 1). The percutaneous drainage was removed 12 days later after progressive output decrement. A CT scan 6 weeks later demonstrated a smaller collection without leakage of contrast medium. The patient continues to do well without evidence of fistula recurrence 12 weeks after the index procedure.

DISCLOSURE

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