UTILITY OF GEL IMMERSION METHOD FOR TREATING MASSIVE COLONIC DIVERTICULAR BLEEDING

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Background/Aims: In Asia, right-sided diverticular bleeding is more common than that of the left side. It often causes massive bleeding and difficulties in identifying the stigmata of recent hemorrhage (SRH) of colonic diverticular bleeding (CDB). This case series demonstrates the efficacy of the gel immersion method using OS-1 Jelly in patients with CDB. Methods: This retrospective case series analyzed data of patients with CDB who underwent the gel immersion method from April 2016 to February 2020. All patients diagnosed with CDB who underwent the gel immersion method were included. We collected data on the site of bleeding, identification of SRH, and efficacy of the method from the electronic medical records. Results: A total of 9 patients (including 7 with right-sided CDB) underwent gel immersion method and were included in this study. SRH were successfully found in 66.7% (6/9) of patients. Moreover, effective hemostasis was achieved in 85.7% (6/7) of patients with right-sided CDB. There were no adverse events. Conclusions: The gel immersion method was found to be effective, especially for massive right-sided CDB.

RESTORATION OF COLONIC CONTINUITY UTILIZING AN EUS-GUIDED RENDEZVOUS PROCEDURE

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Background and case introduction: Post-surgical colorectal anastomoses are complicated by strictures in 2-5.8% of cases. However, complete fibrotic occlusion of the anastomosis is exceedingly rare, and management is not well established. Surgical revision is often recommended, but can be technically difficult. Endoscopic intervention is limited to case reports, including the use of biliary sphincterotomes or electrosurgical knives followed by balloon dilation for luminal recanalization. However, puncture of the blind end of the anastomosis may lead to perforation as well as injury to surrounding vascular structures. We describe the management of a completely obliterated colorectal anastomosis utilizing an endoscopic ultrasound (EUS)-guided rendezvous procedure to restore luminal continuity. A 73-year-old man was diagnosed with a T4N0M0 colorectal cancer. He underwent a low anterior resection with a left coloproctostomy and diverting loop ileostomy. Prior to ileostomy takedown, a barium enema was obtained which showed no passage of contrast beyond the proximal rectum. A flexible sigmoidoscopy demonstrated complete occlusion with scarring of the colorectal anastomosis. Biopsies were negative for malignancy. The patient was referred to our institution for consideration of endoscopic intervention. Description of the procedure: An EUS-guided rendezvous procedure to restore colonic continuity was performed, facilitated by antegrade access to the anastomotic obstruction via the loop ileostomy. A single balloon enteroscope without the overtube was passed antegrade through the ileostomy toward the anastomotic obstruction. A linear echoendoscope positioned in the rectal remnant confirmed no major vascular structures prior to fine needle puncture and passage of a guidewire above the occluded anastomosis. With the guidewire maintained taut at both ends and under endoscopic and fluoroscopic view, a lumen-apposing metal stent (LAMS) was placed and deployed successfully across the anastomosis, resulting in recanalization and establishment of luminal continuity. At 1-month follow-up, the LAMS was fully expanded across the anastomosis, allowing easy endoscope passage into the proximal colon. The LAMS was removed and the anastomotic site balloon dilated to 18 mm. Fluoroscopic contrast injection showed anastomotic patency without extraluminal leak. Clinical Implications: Major revisional surgery may be avoided in select patients with intestinal access that enables an EUS-guided endoscopic rendezvous approach to restore luminal continuity. Conclusion: Restoration of intestinal continuity utilizing an endoscopic rendezvous approach is feasible in select patients with complete fibrotic obstruction at the colorectal anastomosis. An EUS-guided rendezvous approach is advised to avoid the risk of injury to surrounding vascular structures during luminal recanalization.