A 48-year-old woman underwent gastric-bypass surgery for obesity management. This was followed by the adverse event of a Peterson’s hernia. Attempts to repair the hernia failed and were complicated by extensive postoperative small-bowel ischemia. The patient underwent multiple laparotomies, right hemicolectomy, small-bowel resection with end jejunostomy, a blind-ending esophagus into the gastric pouch, and rectal stump with mucous fistula.

Total parenteral nutrition was begun to support the patient’s nutritional needs until reanastomosis surgery could be appropriately planned. She was left with a naso-gastric (NG) tube in situ to allow drainage of her gastric secretions and her saliva. This was causing significant discomfort to the patient because of recurrent blockage of the NG tube and recurrent infections. A PEG and radiologically inserted gastrostomy were both unsuitable because of the deep location of the gastric stump in relation to the skin, and further surgery was not appropriate because future reanastomosis surgery was planned.

At a gastroenterology multidisciplinary meeting, it was decided to create a gastrogastric fistula by use of a lumen-apposing metal stent (LAMS; Hot Axios; Boston Scientific, Hemel Hempstead, UK) (Video 1, available online at www.VideoGIE.org). This was a combined procedure between the endoscopy and interventional radiology teams, with the patient under general anesthesia. Intravenous antibiotics were given before the procedure. The distal gastric remnant was accessed through the jejunostomy with a 5F multipurpose angiographic
catheter and Terumo (Terumo, Tokyo, Japan) guidewire (Fig. 1). A 7F destination sheath was then passed to the stomach, and this was then distended with normal saline solution. EUS of the proximal gastric stump was performed.

The distended distal stomach was identified, and a 19-gauge FNA needle was passed into the distal part of the stomach under EUS guidance (Fig. 2). A cautery guidewire was passed into the distal part of the stomach, snared with a 15-mm gooseneck snare, and delivered through the jejunostomy (Fig. 3). This was to ensure that the wire could be fixed at the skin, to provide tension on the wire to straighten it, thus ensuring adequate stent position and deployment. A 15- × 10-mm LAMS was deployed under US and fluoroscopic guidance, with the distal flange opposed to the gastric wall and proximal flange in the gastric stump. Injection of contrast material showed no leak, and fluoroscopy confirmed the position (Fig. 4). The patient’s NG tube was removed, and gastric secretions drained immediately. Small volumes of liquid were allowed 6 hours after the procedure. Free fluids were started the next day and were tolerated well by the patient.

The patient was discharged on a liquid diet. Esophagoduodenoscopy 6 weeks later confirmed adequate position and patency of the stent (Fig. 5), and the patient was tolerating a

Figure 3. Insertion of gooseneck snare through the destination sheath and grasping of guidewire.

Figure 4. Guidewire brought out through the jejunostomy and fixed at the skin; stent deployed over the guidewire; injection of contrast material to ensure stent patency.

Figure 5. Follow-up gastroscopic view after 6 weeks showing stent in position and patent.
liquid diet. Eleven months later she is well and tolerating a liquid diet. Rejoin surgery is imminently planned, and the stent has been left in situ until this occurs (Fig. 6).

This case is a unique postoperative situation, with a novel approach to allow drainage of gastric secretions and liquid intake. This is the first case to use EUS targeted to a balloon catheter inserted radiologically and allowing the interenteric connection to 2 transected gastric sections.

Khashab et al reported EUS-guided gastroenterostomy and gastrojejunostomy. EUS-guided gastrojejunostomy has been used for gastric-outlet obstruction as an alternative to surgical gastrojejunostomy and enteral self-expanding metal stents with a good safety profile. Lumen-apposing stents and LAMSs have also been used to join the efferent and blind loop in 1 case of efferent loop obstruction after gastrectomy with Roux-en-Y formation.

**DISCLOSURE**

All authors disclosed no financial relationships relevant to this publication.

**Abbreviations:** LAMS, lumen-apposing metal stent; NG, nasogastric.

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