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Surgical treatment of postoperative laparostomy and pyloroduodenostomy—Case report

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ABSTRACT

INTRODUCTION: Postoperative duodenal-cutaneous fistula represents a rare and very complex problem. In most cases operative management becomes necessary, but only after local and systemic stabilization and sepsis control.

CASE PRESENTATION: A 39-year-old man was admitted for surgical management of laparostomy and pyloro-duodenostomy of the first (DI) and second (DII) duodenal segments with one year of evolution, as a complication of several surgical interventions.

The patient had been previously submitted to surgical interventions in another institution for:

1- lower gastrointestinal haemorrhage: treated with total colectomy; 2- upper gastrointestinal haemorrhage: performed a pyloroduodenotomy and pyloroplasty; 3- evisceration: abdominal wall closure; 4- biliary peritonitis due to pyloroplasty dehiscence: submitted to laparotomy with placement of a gastrostomy tube and pyloroduodenostomy tube; 5- intestinal haemorrhage through the pyloroduodenostomy tube: inconclusive exploratory laparotomy plus laparostomy; 6- gastrointestinal haemorrhage and shock: submitted to jejunal segmental resection (haemorrhagic mucous nodule); 7- several complications related to drainage, fistulae and celiostomy.

DISCUSSION: After initial medical treatment for local and systemic stabilization during four months, the following surgical procedures were performed: antrectomy; duodenectomy of DI and the suprapapillary part of DII; T-L gastrojejunostomy; duodenojejunostomy (DII and DIII) L-L at 40 cm of the gastrojejunal anastomosis; T-L jejunojejunostomy; abdominoplasty with a mesh and fibrin glue application; primary cutaneous closure. A multitubular drain was positioned near the duodeno-jejunal anastomosis and a suction drain was positioned in the subcutaneous space.

CONCLUSION: The patient was discharged at the 60th postoperative day, asymptomatic and with a weight gain of 10 kg.

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1. Introduction

Postoperative duodenocutaneous fistula represents a very rare and complex problem. They are associated with significant morbidity due to skin and wound care problems, nutritional abnormalities, malabsorption of fat-soluble vitamins, steatorrhea and rarely sepsis [1]. Intestinal fistulas are first treated medically [2]. In patients whose fistulas do not resolve with conservative management, operative management becomes necessary [3]. However, because of the technical difficulty of dissection, surgery is reserved for cases of failure of expectant and endoscopic management [4,5]. In most cases operative management becomes necessary with bowel resec-

tion and reconstruction of the abdominal wall, but only after sepsis control and local and systemic stabilization.

The authors present the surgical treatment of a very complex pylorostomy, duodenostomy of DI and DII with major duodenal papilla exposure.

This work is reported in line with the SCARE criteria [18].

2. Case presentation

A 39-year-old man was admitted in our Hospital for surgical treatment of laparostomy and pyloroduodenostomy of the first (DI) and second (DII) duodenal parts, with one year of evolution, as a complication of several surgical operations (Fig. 1).

The patient had been submitted to several surgical interventions in another institution, within a period of 30 days, successively by:

1- lower gastrointestinal bleeding and shock (total colectomy); 2- upper gastrointestinal bleeding and shock (pyloroduodenotomy and pyloroplasty); 3- evisceration; 4- biliary peritonitis due to

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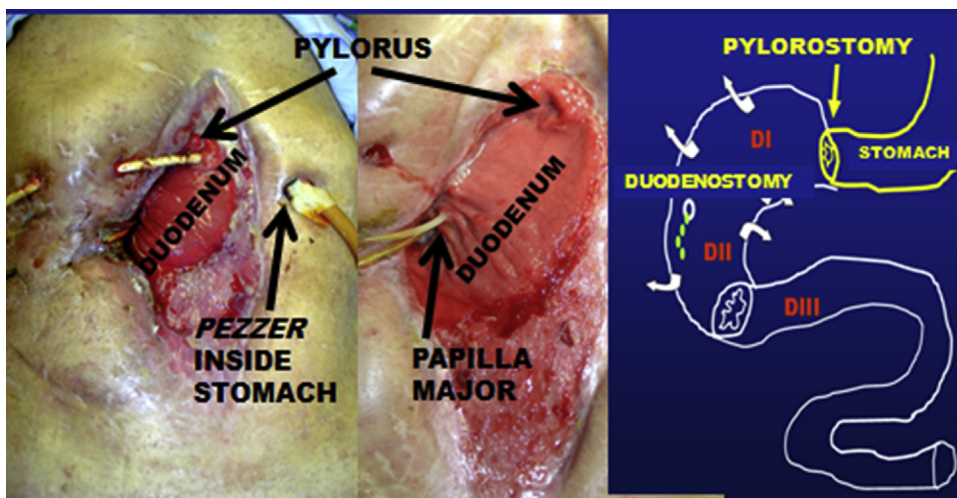


Fig. 1. Laparostomy and pyloroduodenostomy of the first (D1) and second (DII) duodenal parts.

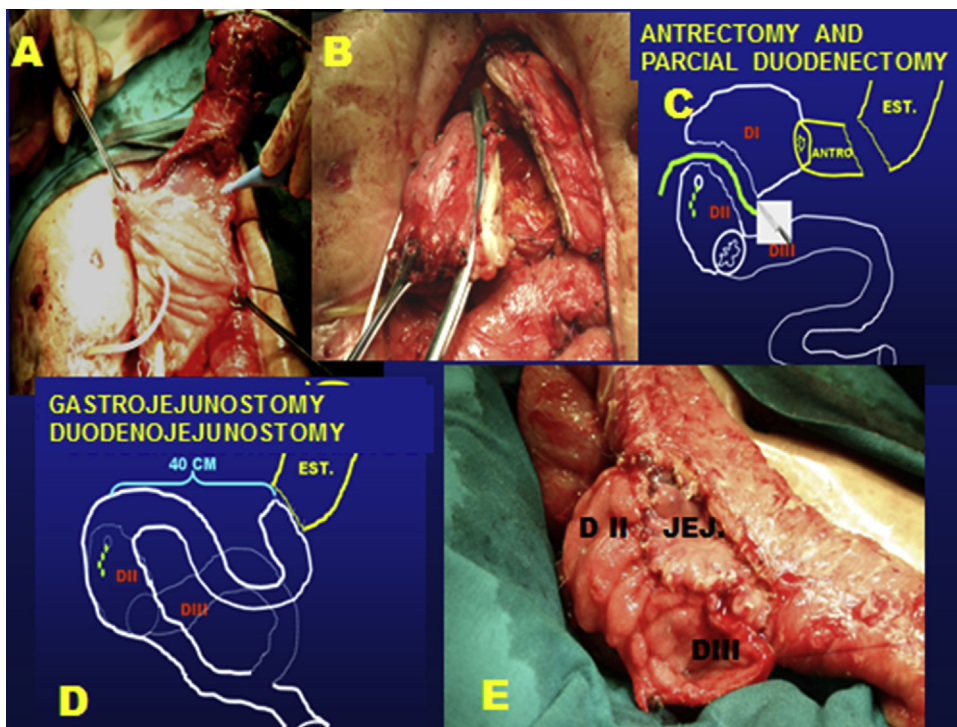


Fig. 2. (A–C) Antrectomy and duodenectomy of D1 and duodenectomy of the suprapapillary part of DII; (D,E) gastrojejunostomy (end-to-side), duodenojejunostomy (DII and DIII) side-to-side at 40 cm of the gastrojejunal anastomosis, and jejunojejunostomy.

pyloroplasty dehiscence (gastrostomy tube and pyloroduodenostomy tube); 5- intestinal bleeding through pyloroduodenostomy tube (inconclusive exploratory laparotomy + laparostomy); 6- gastrointestinal bleeding and shock (jejunal segmental resection by hemorrhagic mucous nodule – degenerative lesion?, adenocarcinoma?); 7- several complications related to drainage, fistulae and celiostomy.

Initially the patient received medical treatment at the origin Hospital for local and systemic stabilization (control of sepsis, enteral and parenteral nutrition), for four months. Immediate surgery could not be performed because the tissues would be sub-optimal because of malnutrition and chronic inflammation.

Four months later at our Hospital the following surgical procedures were performed: circumferential para-celiostomic incision in a non-inflamed tissue; extensive lysis of dense intestinal adhesions;

dissection and identification of the gastric antrum and antrectomy; dissection and identification of the first (D1) and second (DII) duodenal parts; duodenectomy of D1 and duodenectomy of the suprapapillary part of DII; gastrojejunostomy (end-to-side) (T-L); duodenojejunostomy (DII and DIII) side-to-side (L-L) at 40 cm of the gastrojejunal anastomosis; jejunojejunostomy T-L (Fig. 2). Abdominal Wall plasty with a mesh (polypropylene, polydioxanone and regenerated cellulose), application of fibrin glue and primary cutaneous suture. Multitubular drain near the duodenal anastomosis and subcutaneous suction drainage were set (Fig. 3). The patient started oral feeding seven days after the surgical intervention. The post-operative period was complicated by a subcutaneous seroma treated successively by drainage, serum instillation and fibrin glue application. The patient was discharged at the 60th postoperative day with a weight gain of 10 kg (Fig. 3).

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