

CONVERGENCES ENTRE

ENDOSCOPIE ET

ONCOLOGIE DIGESTIVE



ORGANISÉ PAR  
MEETING-PRO

18 Juin 2021  
9h - 17h30

# Traitements des complications de la chirurgie bariatrique

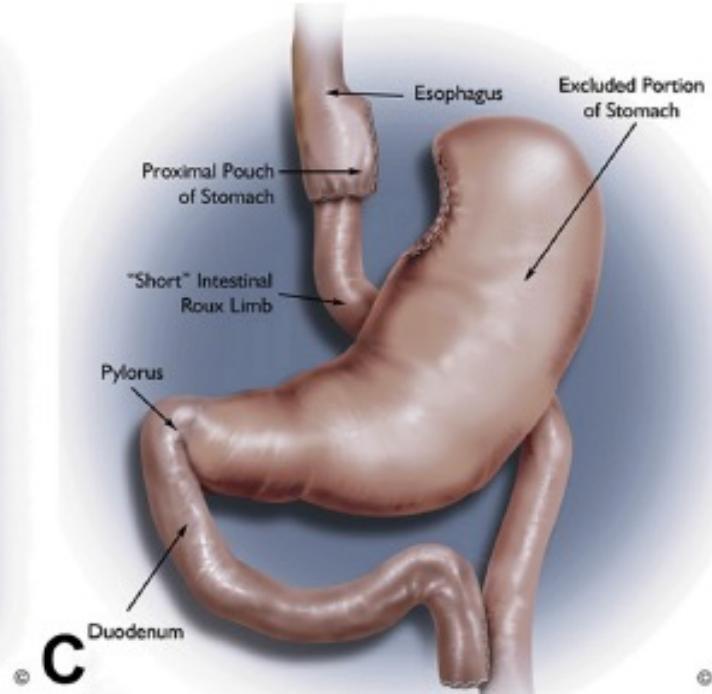
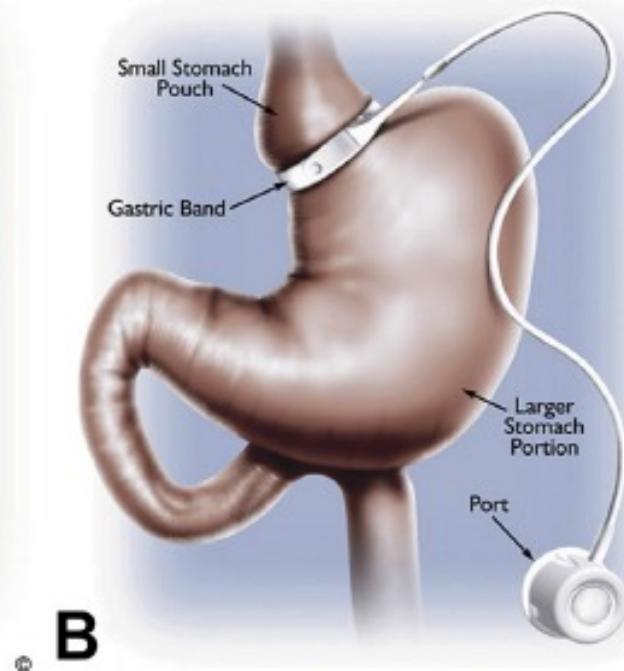
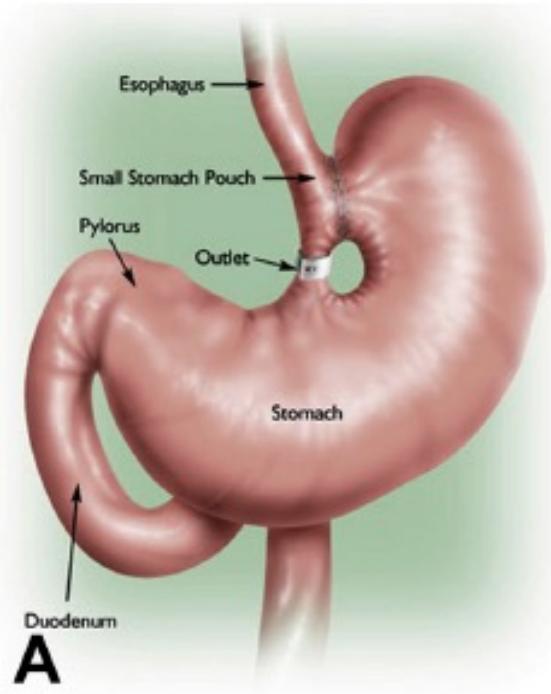
Sarah LEBLANC

[s.leblanc@gelmad.fr](mailto:s.leblanc@gelmad.fr)

Hôpital Privé Jean Mermoz – Médipole Lyon Villeurbanne

# Matériel

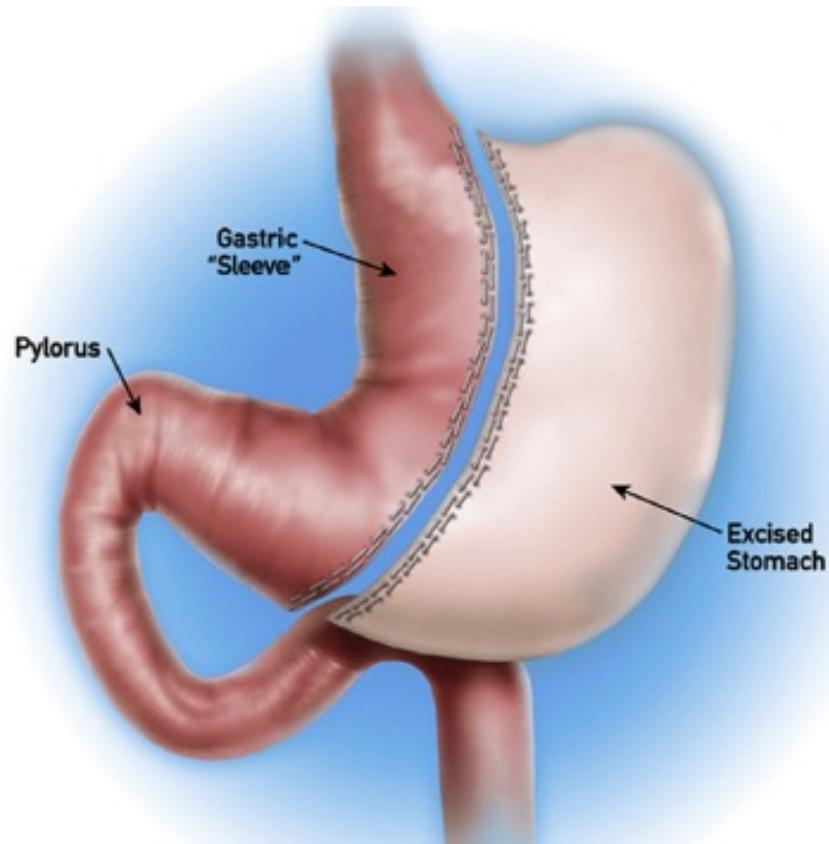
- Patient intubé, table de scopie
- Gastroscope
- +/- cap
- Insufflation CO2
- Pompe de lavage
- Matériel de drainage/prothèse... et le reste...



GVC

Anneau

RYGB



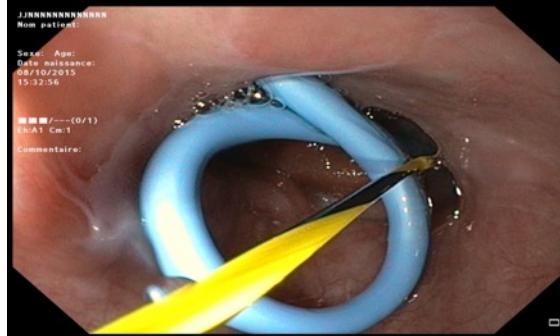
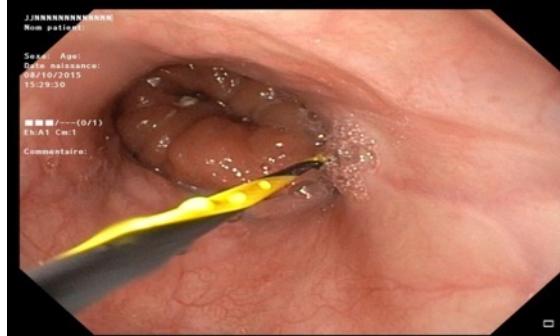
Sleeve

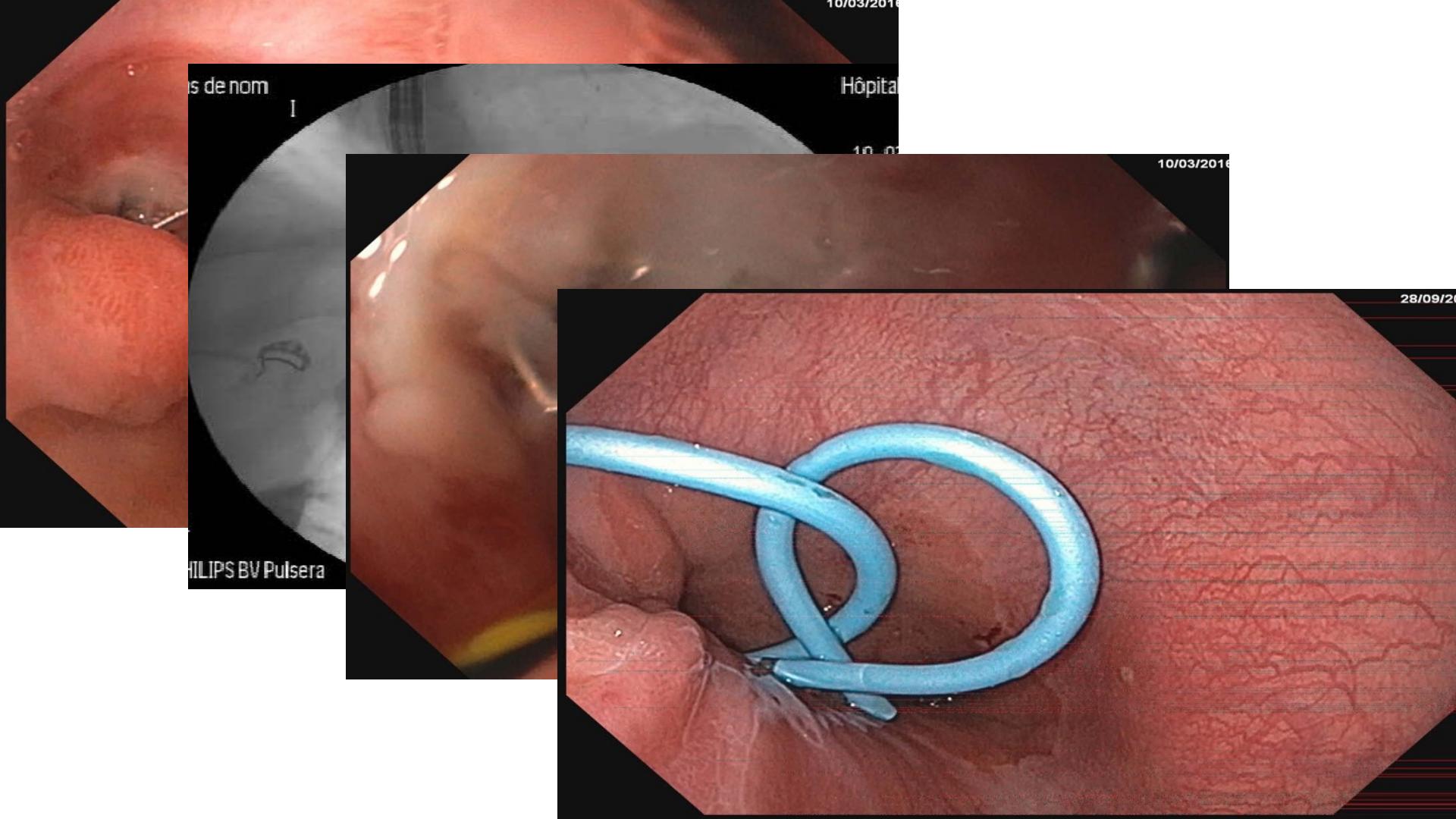
# Fistules

- Identifier **l'orifice** de fistule (cap)
- Identifier **le trajet**: fil guide + opacification
- Favoriser le **drainage interne** par QDC
- Se méfier des fistules multiples +++

# Drainage interne : Queues de cochon

- Prothèse dans le trajet fistuleux
  - Gastroscope, Cathéter + fil guide
  - 7 Fr, 4 - 7 - 10 cm, atraumatique
- Remplacer le drainage externe par un drainage interne (dérivé traitement PK)
- Réaction à corps étranger : fermeture fistule et rétraction de la cavité
- Nutrition +++





is de nom

I

10/03/2016

Hôpital

10/03/2016

10/03/2016

28/09/2016

PHILIPS BV Pulsera

- F, 65ans
- Anneau gastrique -> GVC -> By pass
- Collection sous diaphragmatique G à J5

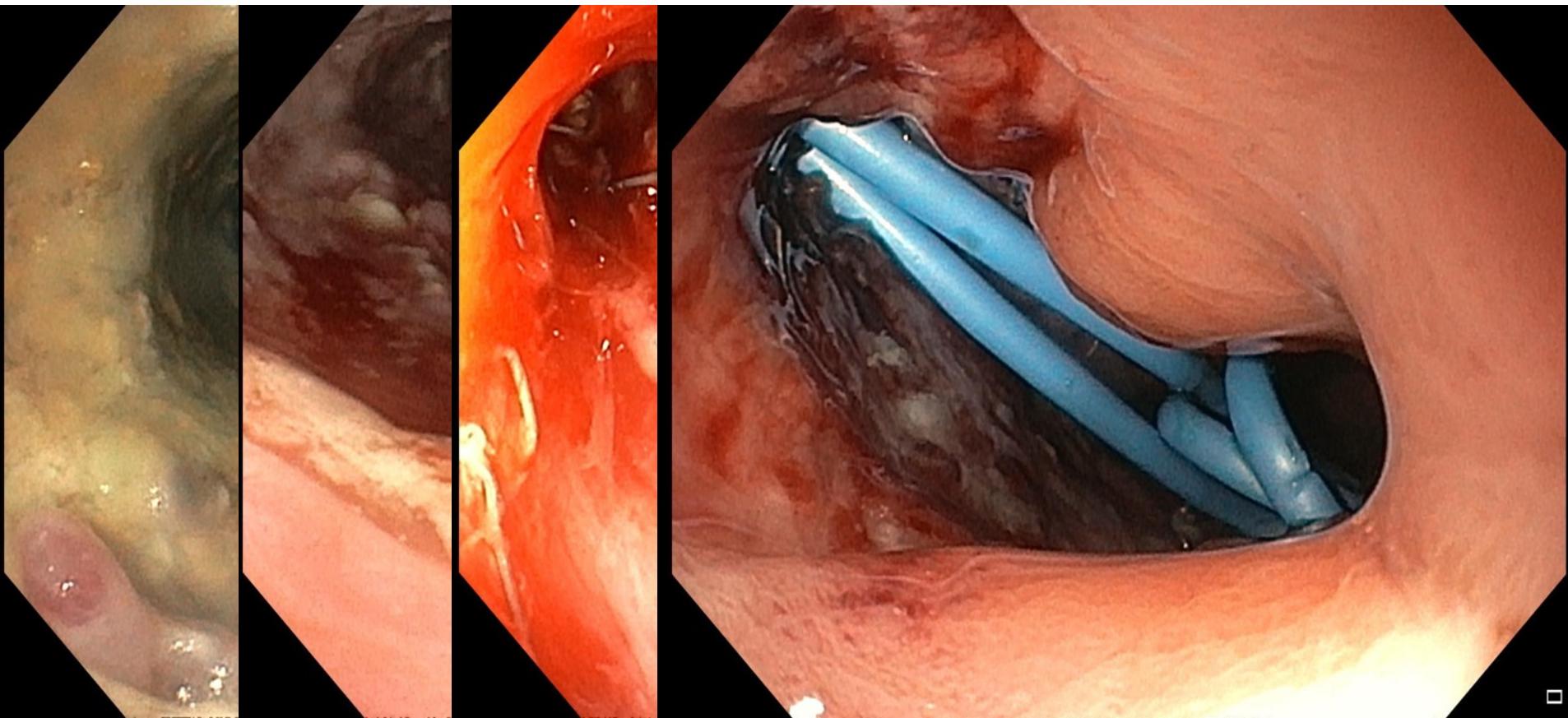
# 1<sup>ère</sup> endo: « classique »

- AGJ ulcérée, pas fistule
  - Fistule en sous cardinal, sur la ligne de suture verticale de la poche gastrique
- > QDC X 2, 7Fr – 4cm
- > sepsis sévère à J3

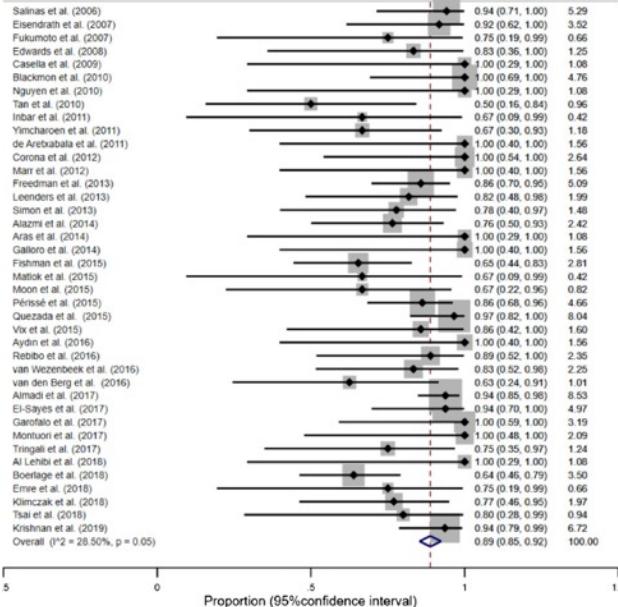
2<sup>ème</sup> endo



# 3<sup>ème</sup> endo: ablation de la prothèse à S4



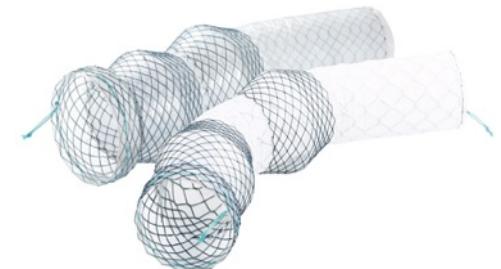
# Prothèses



Prothèse oesophagiennes complètement couverte  
Durée: 3-4 sem  
Alimentation orale

Taux de fermeture: 89-92%

Béta stent  
Taewoong, Corée



Endoscopic management of leaks and fistulas after bariatric surgery:  
a systematic review and meta-analysis

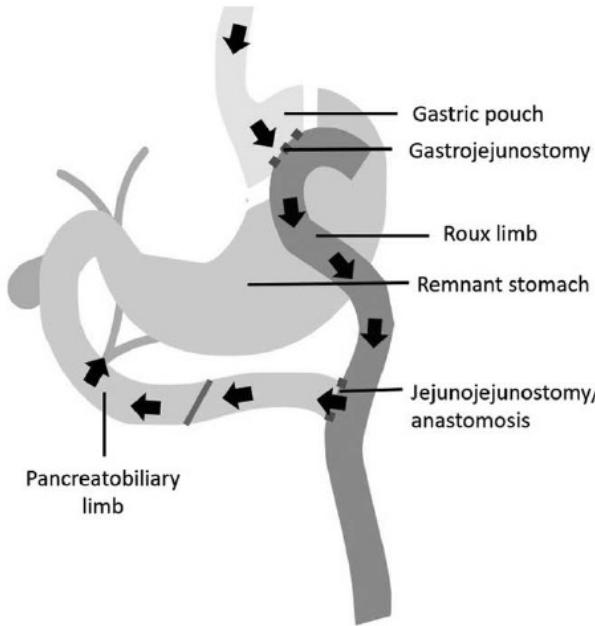
Rogalski, Surg Endosc 2021

# Hémorragie

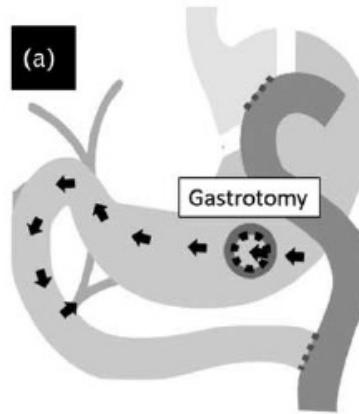
- 34 ans, sleeve gastrectomie + fistule chronique
- Reprise chirurgicale pour by pass
- J3: méléna + déglobulisation
- TDM: pas complication



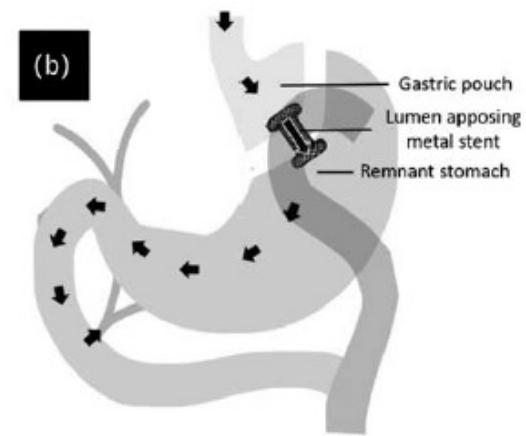
# Lithiase cholédocienne et RYGB



E-ERCP

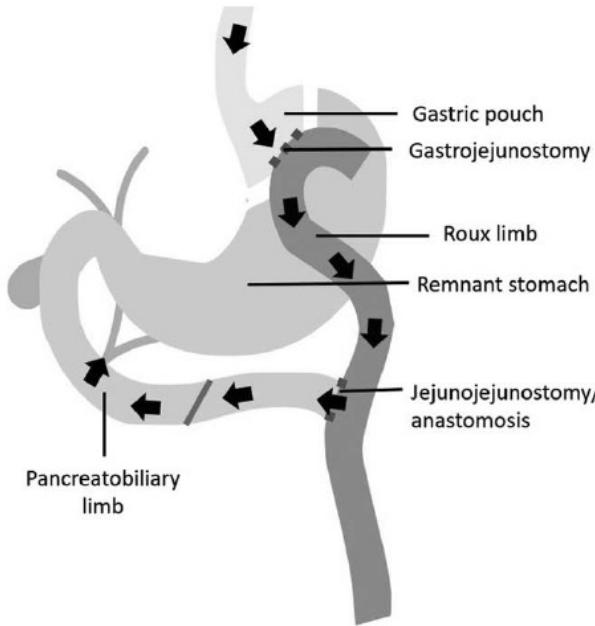


LA-ERCP

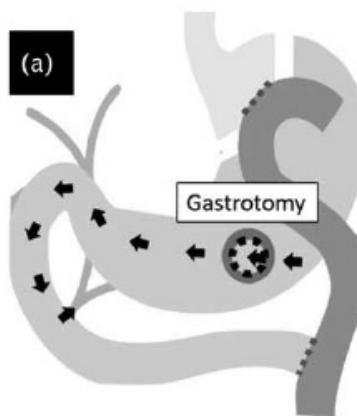


EDGE

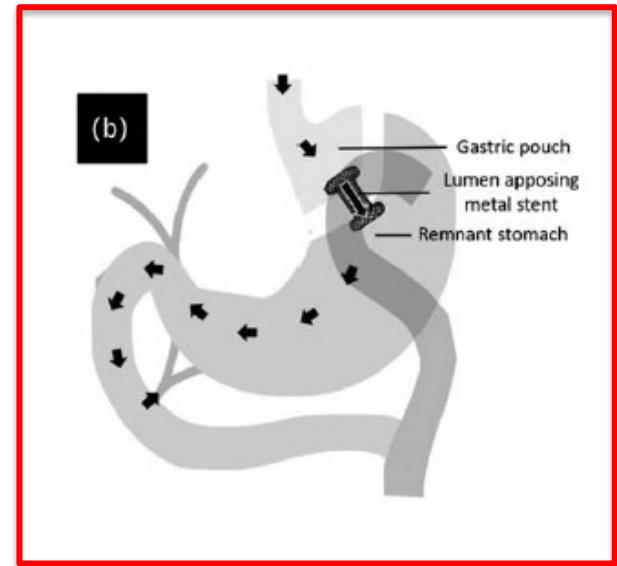
# Lithiase cholédocienne et RYGB



E-ERCP



LA-ERCP



EDGE

# **EDGE (EUS directed transgastric ERCP)**



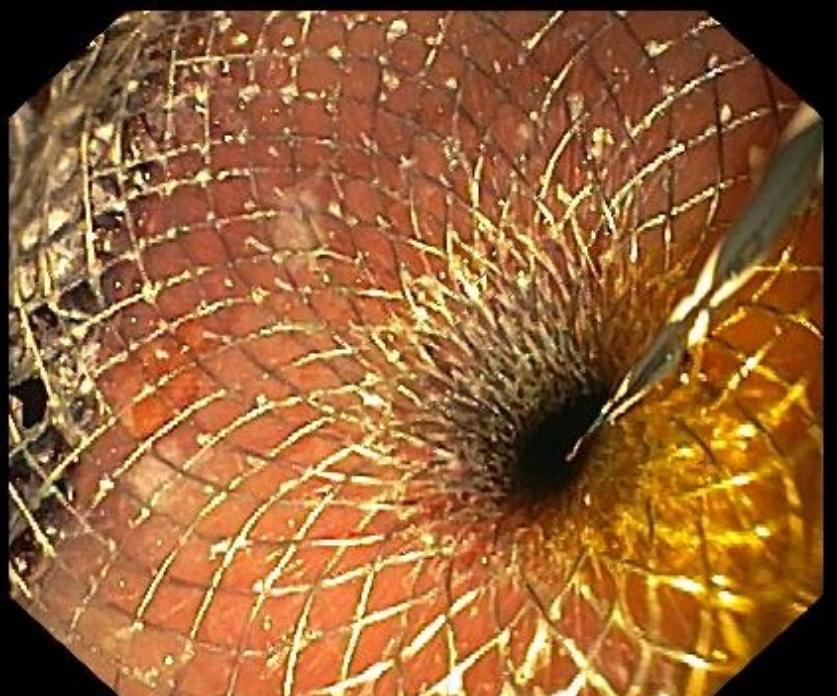
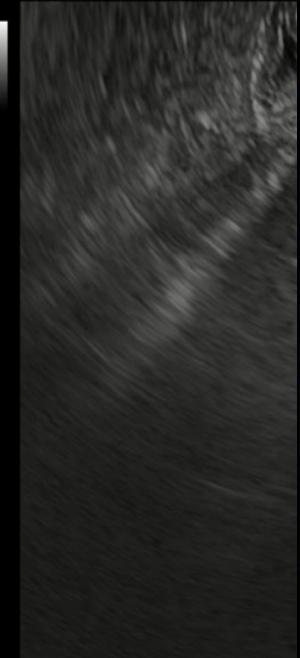
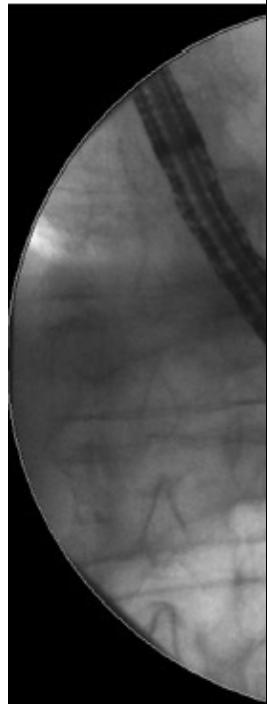
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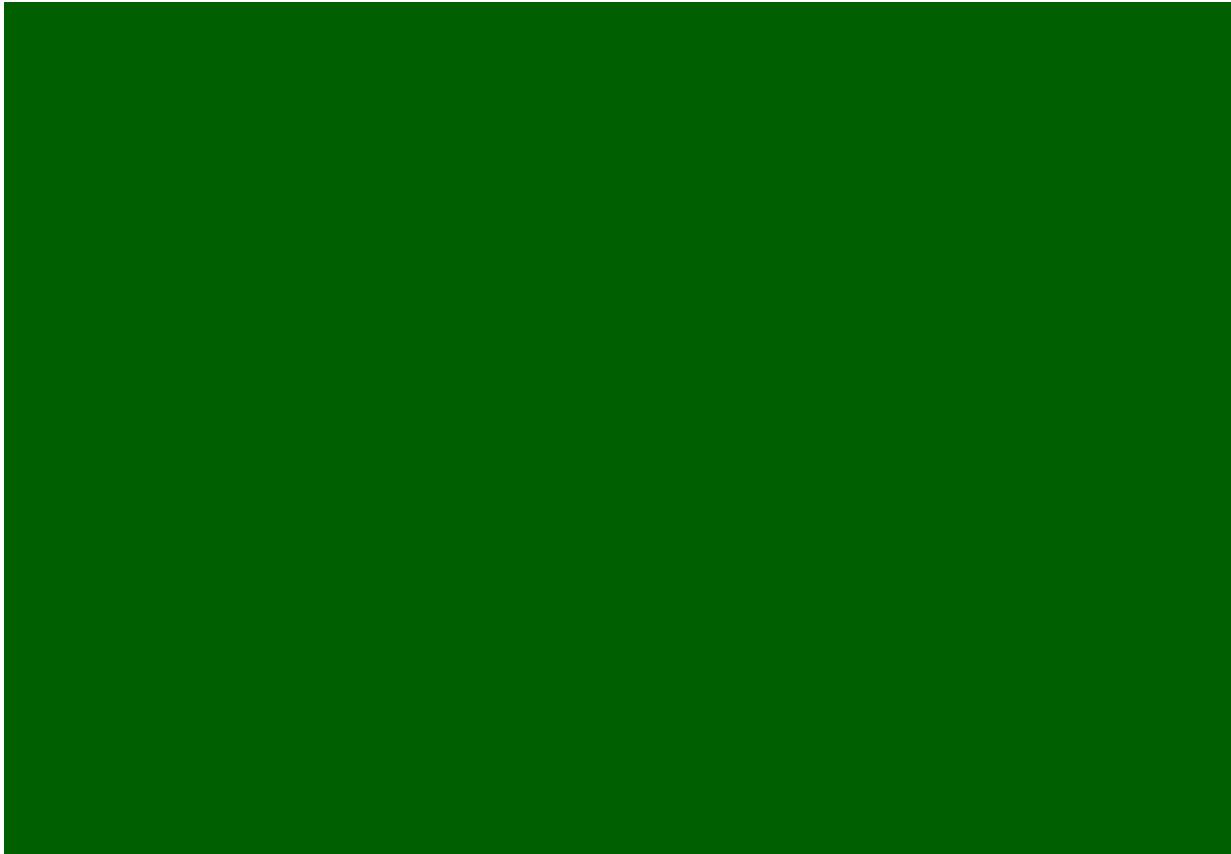
Hopital Prive  
DDN:

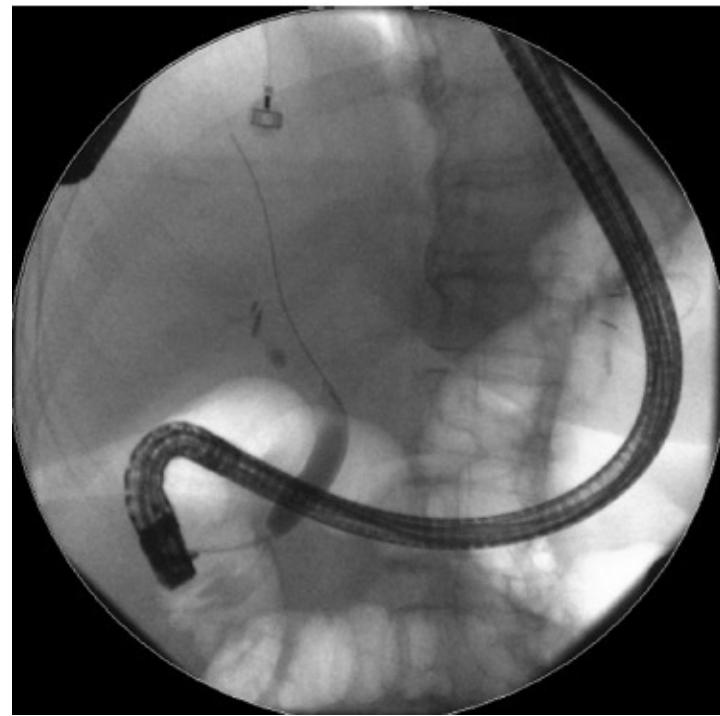
TX :100%  
MI :0.6  
TIS:<0.4

6MHz

G :15  
C : 4







# Résultats

Clinical Characteristics	EDGE	LA-ERCP	P
Technical success of achieving excluded stomach access [n/N (%)]	28/29 (96.5)	43/43 (100)	0.40
Technical success of achieving therapeutic ERCP [n/N (%)]	28/29 (96.5)	42/43 (97.7)	1.0
Total number of ERCP	1.2 (1-3)	1.04 (1-2)	0.0544
Adverse events [n/N (%)]	7/29 (24.1)	8/43 (18.6)	0.57
Cumulative procedure time (min)	73 (24-230)	184 (55-393)	0.00001
Total hospital stay (d)	0.8 (0-5)	2.65 (1-12)	0.00008

	EDGE (n=26)	LA-ERCP (n=18)	E-ERCP (n=12)
Succès technique	100%	94%	75
Complications	8% saigt 4% LAMS migration	6% PA	25% saigt 8% infection 8% PA

Kedia, J Clin Gastroenterol 2018

Kocchar, EIO 2020

Communication  
from the Standards  
of Practice  
Committee

GUIDELINE



## The role of endoscopy in the bariatric surgery patient

GIE, 2015