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Case Report

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Mini Laparotomy Technique for Trans Gastric Walled of Necrosis Drainage

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1. Abstract

Walled of Necrosis is a consequence of acute pancreatitis which may require intervention if symptomatic. The technique demonstrated in video is using small incision (Mini laparotomy) to perform trans gastric open drainage or necrosectomy. Careful case selection is must to choose this technique. It is helpful to achieve complete drainage of necrotic material as well as haemostasis in single sitting.

2. Background

Walled of Necrosis is a consequence of acute pancreatitis which may require intervention if symptomatic. Trans gastric cystogastrostomy with necrosectomy by open method have been evolved towards laparoscopic and endoscopic approach. Surgical trans gastric necrosectomy is an excellent 1-stage surgical option for symptomatic WON in a highly selected group of patients [1]. Laparoscopic approach have shown benefits over open method proved as novel, minimally invasive technique for the management of pancreatic necrosis that allows for debridement in a single operation [2]. Endoscopic necrosectomy showing promising results. In patients with infected necrotizing pancreatitis. Endoscopic necrosectomy reduced the proinflammatory response as well as the composite clinical end point compared with surgical necrosectomy [3].

3. Method

21-year-old male patient with history of acute pancreatitis 3 months back presented with pain in abdomen associated with vomiting. On examination well defined lump was palpable in epigastric, umbilical and left hypochondria. His CT scan showed a large walled of collection in lesser sac pushing stomach anteriorly. Lump was well marked on the bases of its location in imaging for a small incision drainage called as mini laparotomy. Around 3 cm incision was used to enter the abdomen. After anterior gastrotomy edges were sutured making a flap with skin to prevent any spillage of fluid or necrosis in peritoneal cavity. Sufficient posterior wall opening was made to drain out walled of pancreatic collection. After lavage posterior gastric wall sutures were taken with pseudo cyst wall (Cystogastrostomy). Nasogastric tube placed in cavity through this opening. Anterior gastrotomy and abdominal incision was closed without any external drainage tube. Post operatively he was shifted to ward and orals were allowed from next day. Cyst drainage tube was removed on third day.

4. Discussion

The technique demonstrated in video is using small incision (Mini laparotomy) to perform trans gastric drainage of pancreatic collection or necrosis and cystogastrostomy. Careful case selection is must to choose this technique. Walled of collection with or without necrosis in lesser sac opposing posterior wall of stomach after 3 to 5 weeks of acute pancreatitis event can be dealt by this approach. Advantage is a single sitting procedure without any spillage or external drains. Another advantage is to have direct visualisation of entire cavity using a rigid scope through posterior wall opening. It is helpful to achieve complete drainage of necrotic material as well as haemostasis.

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