Gastric Tube Reconstruction with Superdrainage Using Indocyanine Green Fluorescence During Esophagectomy

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Abstract. We report a case of gastric tube reconstruction with superdrainage using indocyanine green fluorescence during esophagectomy for esophageal cancer. A 53-year-old man with a history of early esophageal cancer treated with endoscopic mucosal dissection experienced esophageal cancer recurrence. There was no evidence of lymph node involvement or distant metastasis on computed tomography; therefore, we performed thoracoscopic esophagectomy. After thoracoscopic esophagectomy, we created a gastric tube. When pulling up the gastric tube through the post-mediastinal route, a root of the right gastroepiploic vein was injured. We subsequently performed superdrainage to avoid congestion of the gastric tube with omental vein and pre-tracheal vein anastomosis at the neck, and confirmed venous flow using the indocyanine green fluorescence method. No postoperative anastomotic leakage was observed, and the patient was discharged 22 days after surgery. Thus, we recommend the indocyanine green fluorescence method in cases involving superdrainage during esophagectomy.

Esophagectomy followed by gastric tube reconstruction is a common surgical technique utilized in the management of esophageal squamous cell carcinoma (ESCC) because the stomach wall is supplied by a rich arterial network. Therefore, there is a low risk of necrosis compared with that in other organ conduits including the colon (1).

Although an arterial blood supply to the anastomosis is essential, adequate venous return is also important to avoid congestion, which might result in anastomotic leakage (2). Superdrainage with anastomosis of a gastric vein in the gastric tube has been reported to improve gastric circulation, resulting in avoidance of congestion of the

Discussion

Anastomotic leakage is a problematic complication after esophagectomy and might affect postoperative survival (3). Both reduced arterial blood supply and venous return in the gastric tube might contribute to anastomotic leakage during esophagectomy. Superdrainage with anastomosis of a gastric vein in the gastric tube has been reported to improve gastric circulation, resulting in avoidance of congestion of the
gastric tube (4). However, it is imperative to confirm venous flow through the anastomosis to avoid occlusion or thrombosis (5) after venous anastomosis.

The usefulness of an ICG fluorescence method during reconstruction after esophagectomy (6) or angiography of a coronary bypass graft (7) has been reported. We have previously used ICG to visualize the arterial networks in the stomach before creating the gastric tube during esophagectomy (1). In the present case, we could visualize the blood flow through the venous anastomosis, resulting in successful reconstruction despite the RGEV injury. In addition, the ICG test can be performed repeatedly without any adverse events.

One of the limitations of the ICG assessment is that this is a subjective assessment and no standardized cut-off for anastomotic leakage has been established to date. Therefore, future studies should aim to establish more quantitative assessment methods such as measuring ICG intensity (8) or blood flow speed (9).

**Conclusion**

The ICG fluorescence assessment might be useful not only for visualizing the arterial blood supply to the gastric tube, but also for venous return during superdrainage. We recommend the use of ICG fluorescence in cases where venous anastomosis is needed during reconstruction after esophagectomy.

**Conflicts of Interest**

None declared.
References


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