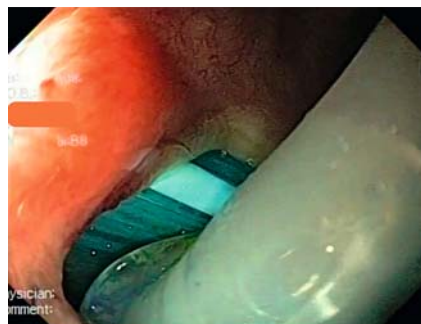


Endoscopic vacuum therapy in a patient without nasal access



► **Fig. 1** Transmurular defect in duodenal bulb.

Usually, upper gastrointestinal (GI) vacuum therapy is delivered through a nasal tube [1]. Herein we report a case in which this access route was not feasible. A 44-year-old man with a previous medical history of a T4aN2M0 extensive squamous-cell lip carcinoma, treated with neoadjuvant chemoradiotherapy followed by tumor resection (including rhinectomy) with surgical defect reconstruction 3 years before admission, was admitted owing to abdominal pain. Computed tomography showed a large pneumoperitoneum. The patient was submitted to an exploratory laparotomy, and a perforated duodenal ulcer was diagnosed and sutured.

Thirteen days after admission, owing to a high volume of drainage of enteric content through the peritoneal drain, a second surgery was performed in an attempt to close the persistent leakage. A gastrostomy tube was placed through the duodenal perforation and the abdominal drain was relocated. One month after the last surgery, the enteric drainage recurred and the patient was submitted to an upper endoscopy, which demonstrated a gastrostomy tube located through



► **Video 1** Endoscopic vacuum therapy in a patient without nasal access.

the anterior wall of the duodenal bulb that, when deflated, allowed the visualization of a transmurular defect with the gastrostomy tube path and abdominal drain (► **Fig. 1**, ► **Video 1**). The gastrostomy tube was removed. A 14-Fr Levine tube was passed through the abdominal drain, creating a tube-in-tube endoscopic vacuum therapy (TT-EVT) [2–4] system for intracavitary therapy. Furthermore, an endoscopic gastrojejunostomy was performed for gastric decompression and enteral feeding. Within 3 weeks after vacuum therapy, the fistula was completely sealed and EVT was interrupted.

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Competing interests

The authors declare that they have no conflict of interest.

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