

Gastro Duodenal Outlet Obstruction is a Complication of Advanced Gastrointestinal Malignant Disease

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Description

Surgical and percutaneous coronary artery intervention revascularization is traditionally considered isolated options. A simultaneous hybrid approach may allow an opportunity to match the best strategy for a particular anatomic lesion. Concerns regarding safety and feasibility of such an approach exist. We examined the safety, feasibility, and early outcomes of a simultaneous hybrid revascularization strategy (minimally invasive direct coronary bypass grafting of the Left Anterior Descending [LAD] artery and Drug-Eluting Stent [DES] to non-LAD lesions) in 13 patients with multivessel coronary artery disease that underwent left internal mammary artery to LAD minimally invasive direct coronary bypass performed through a lateral thoracotomy, followed by stenting of non-LAD lesions, in a fluoroscopy-equipped operating room. Assessment of coagulation parameters was also undertaken. In hospital and post discharge outcomes of these patients were compared to a group of 26 propensity score matched parallel controls that underwent standard off-pump coronary artery bypass. Baseline characteristics were similar in both groups.

Complication Rates

Gastro duodenal outlet obstruction is a complication of advanced gastrointestinal malignant disease. In the past it was usually treated by an open surgical bypass procedure. During the last decade, endoscopic self-expandable stents (SEMS) have been used. The aim of this study was to compare these two palliative strategies concerning clinical outcome and health economy. A series of 36 patients with incurable malignant disease and gastro duodenal outlet obstruction syndrome were treated in a prospective study. According to the attending hospital and endoscopes on duty, 21 of the 36 patients were endoscopic ally treated with SEMS and 15 underwent an open surgical gastroenteroanastomosis. Health economic evaluation was based on the monetary charges for each patient associated with the procedure, postoperative care, and hospital stay. Palliation of the gastro duodenal obstruction in patients with malignant disease was at least as good, and the charges were lower for the endoscopic stenting procedure than for an open surgical bypass. Central venous stenosis and occlusion are complications that are being observed with increasing frequency

as a result of the use of long-term central venous catheters. These complications are especially problematic in patients with end-stage renal disease and functioning ipsilateral arteriovenous (AV) grafts or fistulas (AV grafts). The treatment options for palliating malignant gastro duodenal obstruction include open gastrojejunostomy (OGJ), laparoscopic gastrojejunostomy (LGJ), and endoscopic stenting (ES). The aim of this study was to compare the clinical outcomes and costs among ES, OGJ, and LGJ in patients who present with gastro duodenal obstruction from advanced upper gastrointestinal tract cancer. We designed a model for patients with malignant gastro duodenal obstruction. We analyzed success rates, complication rates and costs of the three treatment modalities: ES, OGJ, and LGJ. Baseline outcomes and costs were based on published reports. Success was defined as no major procedure-related and long-term complications over a 1-month period. Failure of therapy was defined as recurrent symptoms or death due to a procedural complication. Sensitivity analyses and cost-effectiveness analyses for the various strategies were performed. ES resulted in the lowest mortality rate and the lowest cost of the three treatment options analyzed.

Fistula

Venous hypertension due to proximal central venous outflow obstruction coexisting with a functioning arteriovenous fistula in the ipsilateral arm presents with a complex management problem in hemodialysis patients. Ligation of the arteriovenous communication is the simplest procedure to relieve symptoms; however, this sacrifices the patient's hemodialysis access, which may be the only available access in that patient. Surgical bypass of the occlusion is a potential option as it obviates the symptoms of venous hypertension while preserving dialysis access. Our objective was to evaluate our experience and outcome with dialysis patients undergoing surgical bypass for symptomatic central venous obstruction and dialysis access salvage. There were three hemodialysis patients with severe venous hypertension secondary to subclavian vein obstruction who had functioning ipsilateral arteriovenous fistulae. All underwent cephalic vein ($n = 2$) or axillary vein ($n = 1$) to internal jugular vein bypass of the obstructed subclavian segment via an 8-mm polytetrafluoroethylene bridge graft. All patients had unsuccessful percutaneous transluminal angioplasty (PTA)

attempts prior to surgical bypass. In two patients, a wire could not be passed through the occlusion; in the third, PTA was only transiently successful despite four repeated procedures. All patients had complete resolution of symptoms without operative mortality. The bypass grafts remained patent, allowing the arteriovenous fistulae to provide functional access for the

entire duration of follow-up after surgery (3-8 months). Surgical bypass of a central vein obstruction relieves the symptoms of venous hypertension and prolongs the use of the existing hemodialysis access. This surgical option should be well recognized within the dialysis community.