

CLINICAL CASE

Gastroscope
with single-use
gastroscope

EMERGENCY GASTROSCOPY WITH A SINGLE-USE GASTROSCOPE

Dr AMAIA ARRUBLA, Dr JUAN J. VILA

Digestive Endoscopy Unit - Navarra University Hospital

PATIENT HISTORY

63-year-old male with a personal history of dyslipemia, poorly controlled type 2 diabetes mellitus, active smoking and enolism, mild left internal carotid stenosis and multifactorial cognitive impairment. Admission for rib trauma (4 left rib fractures) after fall at home due to dizziness without loss of consciousness. Patient reports poor nocturnal rest due to pain with mobilisation and deep inspiration. Thoracic x-rays show calluses of fractures on the right rib grille and fractures of the posterior-lateral arches of the 5th, 6th, 7th and 8th left ribs, the 7th rib with two fracture lines (Fig. A).

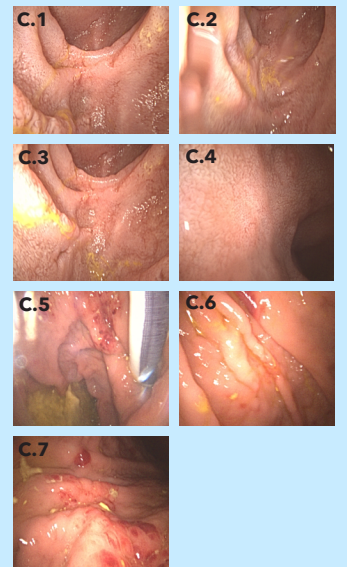
Admission to General Internal Medicine for pain management is decided. A thoracoabdominal CT scan was performed, showing fractures of the posterior arches of left ribs with small thickening and ipsilateral pleural effusion (Fig. B.1-4). In parenchymal window, bilateral emphysema with subpleural bubbles and increased density at left lung base in tarnished glass, likely secondary to contusion. Abdominal images of visceral contusion are not visible. Discreet distension of fasting handles with small liquid tongues between handles. During admission, he presents with hypotension and tachycardia, diaphoresis and poor general condition. Volume replacement is initiated and analysis reveals lactate metabolic acidosis of 5.

With diagnosis of septic shock of unknown origin with possible bacterial translocation component of intestinal origin, he is admitted to the ICU for vasoactive support and progression. Two weeks after admission to the ICU, he presents progressive instability with tension lability (MAP >65mmHg) and a tendency towards tachycardia, with progressive anaemia requiring transfusion of 3 RBC concentrates. In this situation, urgent gastroscopy is requested in the ICU to rule out the digestive origin of bleeding.



PROCEDURE

Gastroscope is performed with the Ambu® aScope™ Gastro in the ICU, targeting the oesophagus with normal mucosa and morphology, and unaltered squamous column junction. In the stomach there are few solid food residues, no blood residues. In the upper body, at least 3 patches of edematous, erythematous mucosa are observed, which impress mild submucosal hematomas, probably in relation to nasogastric tube (Fig. C.5-7). No erosions or ulcers observed. Remaining gastric mucosa without alterations. It is advanced into the duodenum up to 3° portion without observing blood residues or potentially bleeding lesions (Fig. C.1-4). Whitish mucosa is observed, with discreet atrophy of villi and cracked-like mucosa (Fig. C.1-4).



CONCLUSION

With the Ambu aScope Gastro, we were able to perform the complete endoscopy in the patient's own ICU room. All sections of the upper digestive tract could be examined with a high-quality image, excluding digestive origin of bleeding. The Ambu aScope Gastro made it possible to perform the procedure comfortably, with technical quality, without the need to mobilise or transfer the patient, or interfere with the monitoring devices used in the ICU. In this kind of situation, the single-use gastroscope is ideal because it requires very little space for use and can be used for urgent gastroscopy without subsequent disinfection by untrained personnel.

Ambu

Ambu A/S
Baltorpbakken 13
2750 Ballerup
Denmark
Tel.: +45 7225 2000
ambu.com