

# Postoperative complications of gastrectomy

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Radical gastrectomy is complex major surgery and predictably there is a large number of potential complications of the operation. Leakage of the oesophagojejunostomy can often be managed conservatively as the Roux-en-Y reconstruction means that it is mainly saliva and ingested food that leaks. Some patients may establish a fistula from the wound or drain site and others may need radiologically or surgically placed drains. It is unusual to detect a major anastomotic leak in the absence of clinical signs and the use of postoperative water-soluble contrast swallows is no longer routine in most centres. Leakage from the duodenal stump is usually due to a degree of distal obstruction and care must be taken to avoid kinking when performing the Roux-en-Y anastomosis. Para-duodenal collections can be drained radiologically, which may convert the collection into an external fistula. Biliary peritonitis requires a laparotomy and peritoneal toilet. In this circumstance it is best to leave a Foley catheter in the duodenum to establish a controlled duodenal fistula. If it is established that there is no distal obstruction, or if any such obstruction is managed, then the fistula will close with time. The presence of septic collections along with a radical vascular dissection may lead to catastrophic secondary haemorrhage from the exposed or divided blood vessels. This situation may be very difficult to manage, whether or not reoperation or interventional radiology is employed.

(c) Spleen Pancreas (e) Figure 67.30 Radical total gastrectomy: (a) dissection of omentum off the transverse colon; (d) division and oversewing of the duodenum; (e) dissection of the left gastric artery nodes (group 17);

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Revision #1

Created 2025-12-31 15:25:12 UTC by Omar Ayman

Updated 2025-12-31 15:25:12 UTC by Omar Ayman