







Ghost ileostomy: prevention, diagnosis, and early treatment of colorectal anastomosis leakage in advanced ovarian cancer

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In ovarian cancer, modified posterior pelvic exenteration and end-to-end colorectal anastomosis are usually necessary to achieve optimal cytoreduction. Anastomotic leak ranges from 1.7% to 6.8%, and is the main life-threatening scenario after colorectal anastomosis. It has been associated with an increase in morbidity and mortality rates, days of hospitalization, and chemotherapy delays.¹

With regard to the management after colorectal anastomosis, ghost ileostomy has been shown to be a good approach to reduce the rate of protective stoma.^{2,3} The use of ghost ileostomy in conjunction with close post-operative monitoring (C-reactive protein, procalcitonin, and rectoscopy) allows early

and sub-clinical diagnosis of leakage. It can be easily converted into a diverting ileostomy if an anastomotic leakage is suspected, and only requires the loop removal for reversal. During the conversion into a diverting ileostomy it also allows a wash-up of the abdominal cavity to be done and the placement of a percutaneous drainage if indicated. Consequently, ghost ileostomy avoids the disadvantages associated with stoma such as dehydration, malnutrition, renal failure, prolapse, or stricture. Additionally, it also avoids the impact on self-image and quality of life associated with stoma.^{3,4}


We present a case in which end-to-end colorectal anastomosis was performed due to an advanced


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Video 1 Ghost ileostomy: prevention, diagnosis and early treatment of colorectal anastomosis leakage



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Video article

ovarian cancer. A protective ghost ileostomy was performed as follows: a portion of terminal ileum 20 cm distant from the ileocecal valve was identified, the afferent and efferent portions were marked with a long and short stitch, and a vessel loop was placed from the mesenteric border to the abdominal wall at the point of the theoretical stoma.^{2,3}

Post-operatively, C-reactive protein and procalcitonin serum levels were monitored on post-operative days 1 and 3, followed by a low pressure rectoscopy on day 4.¹ Based on normal results, the patient started solid intake. At first defecation she had a sudden clinical worsening and an anastomotic leak was suspected. C-reactive protein and procalcitonin were measured and had risen from basal levels, and a sequential rectoscopy and a computed tomography-enterography showed an anastomotic leakage. Therefore, the ghost ileostomy was converted into a diverting ileostomy at an early clinical stage before fecal peritonitis was established and without re-laparotomy.

Ghost ileostomy represents a real option for tailoring the number of diverting ileostomies performed without increasing the morbidity and mortality. It is a reproducible, safe, and low-cost technique.^{3,4}

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treatment, either in the surgery or in the endoscopic detection of anastomotic leak; (3) drafting of the article; and (4) final approval of the version to be published.

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