

Endoscopic treatment of a completely obstructed ileorectal anastomosis

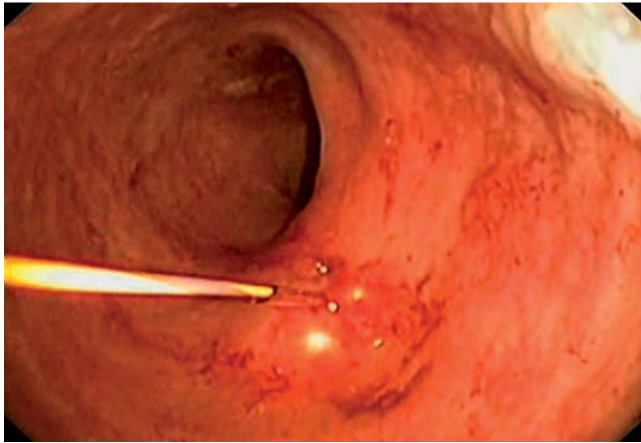


Fig. 1 Endoscopic treatment of a completely obstructed ileorectal anastomosis. A guidewire is passed through a 19-gauge needle.



Fig. 2 Endoscopic view of the second endoscope after balloon dilation.



Fig. 3 Endoscopic aspect of the anastomosis after stent removal.

Complete anastomotic obstruction secondary to a benign disease is rare, with only a few reports of endoscopic management in the literature [1–3]. We describe a case of the successful endoscopic management of a completely obstructed ileorectal anastomosis with the use of an endoscopic rendezvous technique. A 55-year-old man was admitted in September of 2009 for severe alcoholic pancreatitis. Organ necrosis developed, so that subtotal colectomy and lateral ileostomy were required. In May 2010, an ileorectal anastomosis was established, and ileostomy closure was postponed. After 3 months, the patient underwent a rectoscopy, which revealed complete obstruction of the anastomosis. At the same time, a second operator conducted an endoscopic procedure through the ileostomy. Transillumination was obtained from both sides. Fluoroscopy showed that the two endoscope tips were almost in contact with each other. We punctured the upper side of the anastomosis with a 19-gauge needle (Cook Endoscopy, Winston-Salem, North Carolina, USA) and passed a Metro II guidewire (Cook Endoscopy) through the needle (▶ **Fig. 1**). A 10-Fr cystotome (Cook Endoscopy) was then passed from below upward over the guidewire, and dilation with a 10-mm Quantum Maverick balloon (Boston Scientific, Natick, Massachusetts, USA) was carried out (▶ **Fig. 2**), followed by the placement of a fully covered self-expandable Wallstent (Boston Scientific) measuring 80×10 cm (▶ **Video 1**). After 1 week, the stent was removed (▶ **Fig. 3**), and the new orifice was further dilated to 15 mm. At 6 months after the procedure, the patient's bowel habits had returned to normal. Complete obstruction of an anastomosis presents a particular challenge because it requires a real recanalization. The technique of rendezvous was first proposed in the management of complex esophageal strictures [4]. The use of this therapeutic approach to treat complete obstruction of a colorectal anastomosis under fluoroscopic control [5], endoscopic ultrasound [6], or computed tomography [7] has been reported. Our case is, to our knowledge, the first one in which an ileorectal anastomosis was treated.

Video 1

Video showing transillumination of the obstructed anastomosis, puncture with a 19-gauge needle, passage of the guidewire, passage of the cystotome, balloon dilation, and stent deployment. The final result is a functional anastomosis.

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Competing interests: None

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