Colonic stricture following conservative treatment of a colonoscopic perforation

Colonic perforation is a well-known, leading complication of colonoscopy. The incidence of colonic perforation ranges from 0.03% to 0.65% in diagnostic colonoscopies and from 0.07% to 2.14% in therapeutic colonoscopies [1,2].

A 66-year-old woman was admitted for left colonic stricture. This patient had been treated for colonic perforation almost 1 year previously. At that time, she had been undergoing investigation by the gastroenterology department because of intermittent diarrhea. Colonoscopy was otherwise unremarkable with completely normal colorectal findings. The patient developed abdominal pain, nausea, and slight abdominal distension a few hours after colonoscopy. Plain abdominal radiography showed free air under the right diaphragm. Nasogastric decompression, intravenous fluids, and antibiotic treatment were immediately started. The physical examination findings improved gradually. The nasogastric tube was removed on day 5. A computed tomography scan was performed, which showed a normal abdominal image, and the patient was discharged on day 12.

Upon her second admission 9 months later, the patient declared that her bowel habits had gradually changed during the past 3 months. Colonoscopy was intended, but the colonoscopy could not pass through a stricture found on the sigmoid-left colon region. Barium enema confirmed the stricture on the sigmoid junction with inadequate passage of the contrast to the proximal segments (**Fig. 1 a**). The length of the stricture segment was 2–3 cm. We considered performing a balloon dilatation of the short stricture; however, the patient's family did not consent to this treatment. Laparotomy was performed for the symptomatic colonic stricture of unknown nature. A thin, benign-looking stricture that resembled an anastomotic stenosis was found on the very proximal sigmoid colon (**Fig. 1 b–d**. The stricture was not uniformly circumferential. Histopathology revealed only fibrotic changes with no additional abnormalities in or around the narrowed region.

This report describes a late complication of a colonic perforation. Such an occurrence is added to the rare and interesting complications of colonoscopy, such as splenic rupture [3] or transverse mesocolon laceration [4].

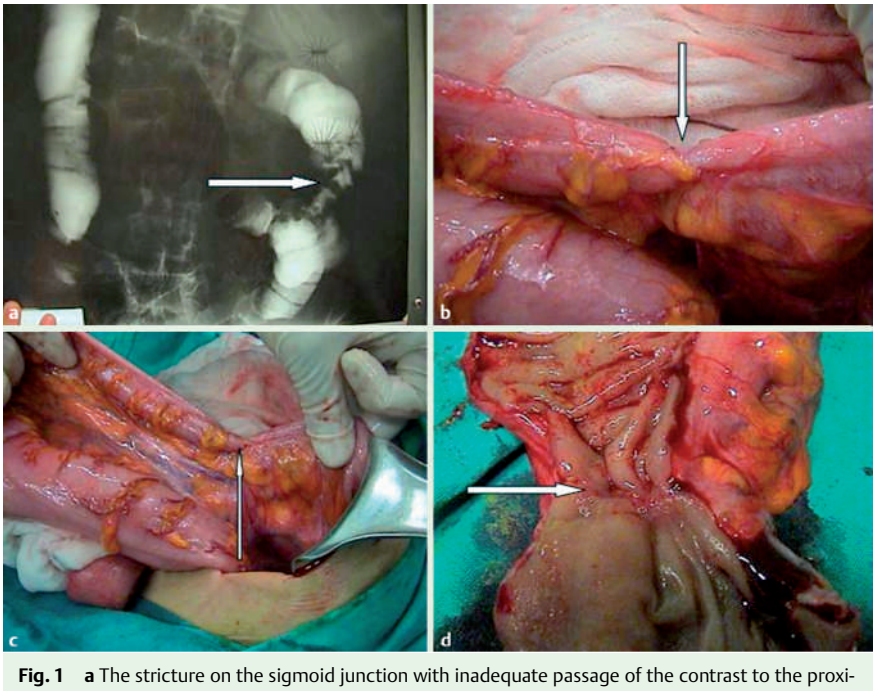


Fig. 1 **a** The stricture on the sigmoid junction with inadequate passage of the contrast to the proximal segments (arrow). **b, c, d** Intraoperative view: a thin benign-looking stricture that resembled an anastomotic stenosis was found on the very proximal sigmoid colon (arrow).

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References

1 *Damore LJ 2nd, Rantis PC, Vernava AM3rd et al.* Colonoscopic perforation: etiology, diagnosis and management. Dis Colon Rectum 1996; 39: 1308 – 1314

2 *Kavic SM, Basson MD.* Complications of endoscopy. Am J Surg 2001; 181: 319 – 332

3 *Taylor FC, Frankl HD, Riemer KD.* Late presentation of splenic trauma after routine colonoscopy. Am J Gastroenterol 1989; 84: 442 – 443

4 *Hernandez EJ, Ellington RT, Harford WV.* Isolated transverse mesocolon laceration during routine colonoscopy. J Clin Gastroenterol 1999; 28: 46 – 48

Bibliography

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