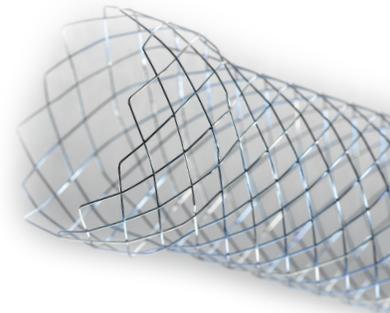


# Colonic Decompression as an Alternative to Diverting Colostomy



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Figure 1

### Patient History

A 69-year-old male presented in the ED with acute bowel obstruction. A colonoscopy was performed and it was determined the obstruction was caused by a malignant neoplasm of the colon. The patient had a surgical consult and had a choice of a two stage Hartmann procedure or a colonic stent placement to decompress the bowel followed by colonic resection. It was decided to proceed with the colonic stent placement in order to reduce the number of surgeries as well as to speed up the time when the resection could take place.

### Procedure

A frond-like, villous, fungating, infiltrative completely obstructing large mass was found in the recto-sigmoid colon. The mass was circumferential and measured 10cm in length. The mass was traversed using a .035 Dreamwire™ Guidewire under fluoroscopic guidance. A 22mm x 120mm WallFlex Colonic Stent was passed through the scope and traversed the stricture. The stent was deployed under both fluoroscopic and endoscopic guidance. (Figure 1) The stent was carried to the rectal vault to avoid the anus. Immediate relief of obstruction was noted. (Figure 2)

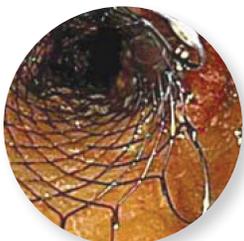


Figure 2

### Post Procedure

During the procedure, immediate decompression was seen as the stent was deployed. (Figure 3) The patient did very well post procedure and was discharged the same day (inpatient). After further testing, it was determined that the patient had metastatic cancer and therefore was not a candidate for surgical intervention.

### Discussion

If the patient is an appropriate candidate for stenting, I always give them that option and tend to encourage that over the diverting colostomy as a preparation for colonic resection. The advantages to the patient are that they have one surgical procedure instead of two and the decompression time may be more comfortable or at least less invasive by passing stool normally instead of into a colostomy bag. Additionally, the percentage of patients who choose not to have the colostomy reversed or are no longer surgical candidates is not insignificant, therefore it makes sense to go with the option your patient would be most comfortable with in the event it becomes a long term fix rather than a preparation for surgical intervention.



Figure 3

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