

Colonic Dilation Ileocecal Anastomosis Abdominal Pain and an Ileocolonic Anastomotic Stricture

CRE™ WIREGUIDED BALLOON DILATOR Technique Spotlight



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Figure 1



Figure 2

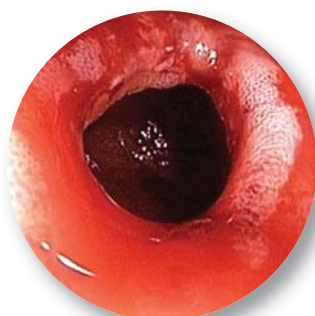


Figure 3

HISTORY

A 62-year-old caucasian female with Crohn's disease had an ileorectal resection two years before presentation. The patient was on azathioprine and a 5-ASA product. She had been suffering intermittent right lower quadrant pain, usually post-prandial with abdominal bloating lasting on average two hours for the last eight months, but she was experiencing two well formed bowel movements a day, with rare diarrhea, and her weight was stable. A colonoscopy performed four months previously showed normal ileorectal anastomosis mucosa, but the scope could not be advanced into the ileum. No endoscopic therapy was performed as previous stool studies, CRP and sedimentation rate were normal. She sought another opinion.

PROCEDURE

A colonoscopy was performed. The ileocolonic anastomosis was reached with ease. The colon mucosa appeared normal. The scope could not be passed beyond the stricture but the ileal mucosa was visualised through the stenotic anastomosis (Figure 1). The residual lumen was estimated to measure 8mm. Because the ileal lumen was well visualised en face, balloon dilatation was performed without fluoroscopic guidance.

The CRE™ Wireguided Balloon Dilator, which is indicated for use in adult and adolescent populations to endoscopically dilate strictures of the alimentary tract, was chosen. The wire assisted in deflecting the balloon tip of the ileal mucosal wall to avoid tip impaction and aided in centering the balloon within the stricture. An 8 to 10mm CRE Wireguided Balloon was used first. Dilatation effect was visualised and controlled by approximating the scope to the proximal end of the balloon. By visualising through the balloon, the blanching and stretching effect of the dilatation was evident (Figure 2). The scope was then advanced with minor resistance into the ileum. Minimal trauma to the mucosa at the stricture was noted. Subsequently, it was obvious that the stricture was still tight around the colonoscope; a 10 to 12mm CRE Wireguided Balloon was used to dilate the stricture further. The scope was then easily passed into the ileum. The ileum was then well visualised, and it appeared intact (Figure 3).

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POST PROCEDURE

The patient was discharged without complaints. Upon phone follow-up a week later, she had not experienced abdominal pain. At six-month follow-up, she remained asymptomatic. She continues medication for Crohn's disease.

DISCUSSION SECTION

This highlights the ease of use of endoscopic dilatation balloons. The guidewire was used to bounce the tip of the balloon off the mucosa to assure inflation well within the ileal lumen. The ability to visualise the tissue effect through the balloon during dilatation was helpful in the decision to continue to dilate up to a size of 12mm safely.

This case reflects the opinion of and is the responsibility of the author.

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