A 31-year-old woman with a 10-year history of ulcerative colitis was seen at our outpatient clinic with complaint of abdominal pain and increased output from her ileostomy. She had previously undergone a subtotal colectomy with an end ileostomy for medically refractory ulcerative colitis in 2008. She then underwent elective complete proctectomy with ileal pouch-anal anastomosis and diverting loop ileostomy 6 months later. We decided to perform pouchoscopy to rule out pouch-related complications (†Video 1). Illeoscopy was performed via the stoma. The terminal ileum appeared normal to 25 cm from stoma. The patient was found to have a diverted pouch outlet stricture. The sealed outlet was detected by a Jagwire (Boston Scientific, Marlborough, Massachusetts, USA). †Video 1 Wire-guided stricturotomy for sealed ileal pouch.

†Fig. 1 Wire-guided stricturotomy of sealed ileal pouch. a Sealed pouch outlet was detected by a Jagwire (Boston Scientific, Marlborough, Massachusetts, USA). b Diverted pouch outlet stricture was noted. c Knife stricturotomy was performed over the guidewire. d Knife stricturotomy was performed in a radial fashion. e Sealed ileal pouch was effectively treated with wire-guided stricturotomy.
wire (Boston Scientific, Marlborough, Massachusetts, USA) (Fig. 1a, b). We then performed knife stricturotomy over the guidewire (Fig. 1c, d). Moderate diversion pouchitis with exudates was noted. We were able to pass the scope without difficulty (Fig. 1e).

The patient tolerated the procedure well without any immediate complications. She reported improvement in her symptoms at the 1-month follow-up visit.

Sealed ileal pouch can be safely and effectively treated with wire-guided endoscopic stricturotomy.

Competing interests

None

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