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. (▶ Video 1). Sealed pouch outlet was detected by a jagwire (Boston Scientific, Marlborough, Massachusetts, USA). Diverted pouch outlet stricture was noted. Knife stricturotomy was performed over the guidewire. Knife stricturotomy was performed in a radial fashion. Sealed ileal pouch was effectively treated with wire-guided stricturotomy.

▶ 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. 1 a, b). We then performed knife stricturotomy over the guidewire (▶Fig. 1 c, d). Moderate diversion pouchitis with exudates was noted. We were able to pass the scope without difficulty (▶Fig. 1 e).

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.

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Competing interests

None

Bibliography

DOI https://doi.org/10.1055/a-0840-3262
Published online: 12.2.2019
Endoscopy 2019; 51: 493–494
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X