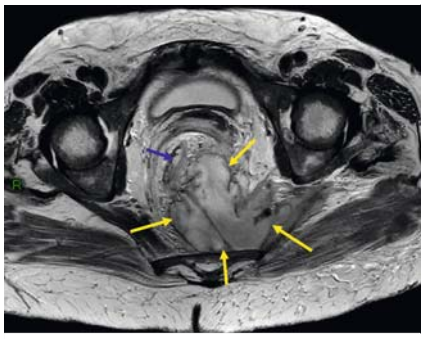
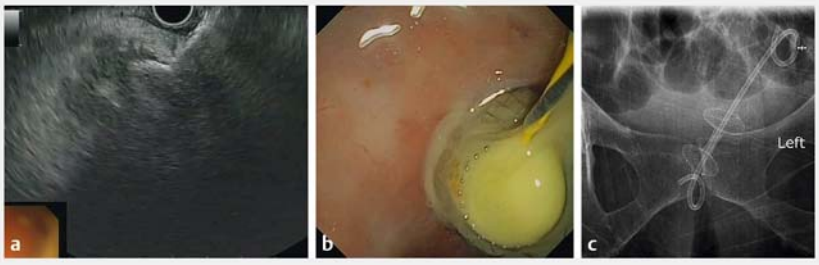
Management of pelvic abscess complicating a rectoanal fistula using endoscopic ultrasound-guided drainage with an electrocautery-enhanced lumen-apposing metal stent



▶ **Fig. 1** View of a large pelvic abscess on magnetic resonance imaging (blue arrow: rectal lumen; orange arrows: pelvic abscess).



▶ **Fig. 2** Endoscopic ultrasound-guided drainage of a pelvic abscess using an electrocautery-enhanced lumen-apposing metal stent (LAMS). **a** Deployment of the proximal flange of the LAMS into the pelvic abscess under EUS guidance. **b** Deployment of the distal flange of the LAMS into the rectal lumen under endoscopic guidance. **c** A double pigtail stent was inserted through the LAMS.

▶ **Fig. 3** Computed tomography 6 months later showed no recurrence of the abscess.

Video 1 Endoscopic management of a pelvic abscess due to rectoanal fistula (orange arrows: pelvic abscess).

The management of pelvic abscess is mainly radiological or surgical [1]. The use of electrocautery-enhanced lumen-apposing metal stents (LAMS) allows efficient drainage of intra-abdominal collections [2]. A few retrospective studies and case series have demonstrated the feasibility and safety of EUS-guided drainage of pelvic abscesses [3–5]. We present a case of a large pelvic abscess complicating a rectoanal fistula that was successfully drained without recurrence using an electrocautery-enhanced LAMS.

During the lockdown due to COVID-19, an 81-year-old woman waited 1 month before attending the emergency room for rectoanal pain with fever. On her admission, computed tomography and magnetic resonance imaging showed a large pelvic abscess measuring 11 cm (▶ **Fig. 1**). The location of the pelvic abscess did not allow for radiological drainage, and the patient's medical history precluded surgical management. EUS-guided drainage of the pelvic abscess was performed a week after the patient's admission (▶ **Video 1**).

The abscess was accessed using a 19-G needle and aspirated purulent liquid was sent for bacteriological analysis. A 0.025-inch guidewire was introduced through the needle into the abscess. The fistula tract was created using the electrocautery-enhanced LAMS (10 × 10 mm). Then, the LAMS was deployed to drain the abscess into the lumen of the colon (▶ **Fig. 2a, b**). During the same procedure, a double pigtail stent was inserted through the LAMS (▶ **Fig. 2c**). No adverse events were reported. At 1 week, endoscopic cleaning of the abscess was performed through the LAMS. The LAMS was re-

moved after 3 weeks and replaced by a double pigtail stent. At 6 months, the double pigtail stent had migrated outwards and the abscess disappeared without recurrence (▶ **Fig. 3**).

This case highlights the use of a LAMS in the drainage of a pelvic abscess and successful outcome without recurrence. Future prospective studies are needed to confirm the use of LAMS for this indication and to determine the place of EUS-guided drainage of pelvic collections.

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Competing interests

The authors declare that they have no conflict of interest.

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Bibliography

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