Perforation upon retroflexion: an endoscopic complication and repair

A 73-year-old man with a history of hypertension and coronary artery disease underwent a diagnostic colonoscopy for iron-deficiency anemia. The patient's physical exam and digital rectal exam were normal. The colonoscopy revealed sigmoid diverticulosis and two small polyps, which were removed. Retroflexion of the colonoscope was performed.

Upon straightening the colonoscope, a 2-cm circular perforation near the rectosigmoid junction, approx. 10–12 cm from the anal verge, was visualized (Fig. 1). Upon identification, ten endoscopic clips were placed sequentially from the ends of the perforation toward the center to close the perforation (Fig. 2 and 3).

Although the patient experienced a distended abdomen and mild epigastric abdominal pain, his vital signs were within normal parameters during and after the procedure. The patient was admitted to the hospital for 5 days and given nothing by mouth for about 48 hours and antibiotics. Two weeks after discharge, he continued to do well without complaints.

Four cases of rectal perforation with retroflexion have been reported, with this case representing the fifth (Table 1) [1, 2]. Surgery or endoscopic closure with observation are the therapeutic options for such perforations. This case represents the second successful demonstration of endoscopic repair using endoclips for a perforation formed upon retroflexion, but the first case occurred above the peritoneal reflection. In addition, this case represents the largest retroflexion-induced perforation (2 cm) to be endoscopically closed. Although colonoscope retroflexion in the rectum improves rectal visualization, the risk of perforation is apparent and should be considered.

Table 1  Details of case reports/series regarding rectal perforations upon retroflexion.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Patient age, years</th>
<th>Perforation size, cm</th>
<th>Distance of perforation from anal verge, cm</th>
<th>Location in relation to peritoneal reflection</th>
<th>Management</th>
<th>Length of hospital stay, days</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chu et al. [1]</td>
<td>76</td>
<td>2</td>
<td>7</td>
<td>Below</td>
<td>Conservative with IV antibiotics</td>
<td>6</td>
<td>Favorable</td>
</tr>
<tr>
<td>Chu et al. [1]</td>
<td>54</td>
<td>3</td>
<td>8</td>
<td>Below</td>
<td>Conservative with IV antibiotics</td>
<td>21</td>
<td>Favorable</td>
</tr>
<tr>
<td>Chu et al. [1]</td>
<td>79</td>
<td>2</td>
<td>5</td>
<td>Below</td>
<td>Conservative with IV antibiotics</td>
<td>10</td>
<td>Favorable</td>
</tr>
<tr>
<td>Ahlawat et al. [2]</td>
<td>60</td>
<td>1–1.5</td>
<td>6–7</td>
<td>Below</td>
<td>Endoscopic repair with conservative management and IV antibiotics</td>
<td>3</td>
<td>Favorable</td>
</tr>
<tr>
<td>Bechtold et al., present case</td>
<td>73</td>
<td>2</td>
<td>10–12</td>
<td>Above</td>
<td>Endoscopic repair with conservative management and IV antibiotics</td>
<td>5</td>
<td>Favorable</td>
</tr>
</tbody>
</table>
References

Bibliography
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