While prior reports have demonstrated the usefulness of endoscopic ultrasound (EUS) for transrectal drainage of pelvic abscesses, its utility for performing drainage via an ileoanal reservoir (J-pouch) has not been reported before.

A 28-year-old patient with a history of total colectomy and a J-pouch for ulcerative colitis presented with persistent fever and rectal pain. Computed tomography (CT) of the pelvis revealed an abscess measuring 5 × 3 cm adjacent to the J-pouch (Fig. 1).

EUS-guided drainage of the abscess was requested because of the lack of an adequate window for percutaneous drainage. A 28-year-old patient with a history of total colectomy and a J-pouch for ulcerative colitis presented with persistent fever and rectal pain. Computed tomography (CT) of the pelvis revealed an abscess measuring 5 × 3 cm adjacent to the J-pouch (Fig. 1).

EUS-guided drainage of the abscess was requested because of the lack of an adequate window for percutaneous drainage. At EUS, the pelvic abscess was punctured (Fig. 2) using a 19-gauge needle (Expect; Boston Scientific, Natick, Massachusetts, USA), and a 0.035-inch guidewire was then coiled into the abscess cavity (Fig. 3) under fluoroscopic guidance. The transmural tract was sequentially dilated using a 5-Fr endoscopic retrograde cholangiopancreatography cannula and a 6-mm balloon dilator (Fig. 4). A 7-Fr double pigtail stent was then deployed into the abscess cavity (Fig. 5).

Postprocedure, the patient was afebrile and had no rectal pain. Follow-up CT revealed complete resolution of the abscess, and so the transrectal stent was retrieved by sigmoidoscopy.

Fitting a J-pouch, sometimes referred to as ileoanal reservoir, involves colectomy with mucosal proctectomy and the creation of an ileal reservoir which is anastomosed to the anal canal [1]. In a meta-analysis, 9.5% of patients with a J-pouch developed pelvic abscess from anastomotic dehiscence [2]. Initial management often includes percutaneous drainage; a persistent abscess may require surgery [3]. In a prior study by myself and a co-author, we have shown that EUS is a minimally invasive alternative for drainage of pelvic abscesses [4]. However, patients with a J-pouch were excluded because of concerns of perforation in a surgically constructed anatomy. Given the inability to treat the pelvic abscess by percutaneous means, we attempted drainage via the J-pouch in this patient, with good clinical outcomes.

Competing interests: None
References


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Bibliography

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