Endoscopic ultrasound-guided drainage of a pelvic abscess via a J-pouch

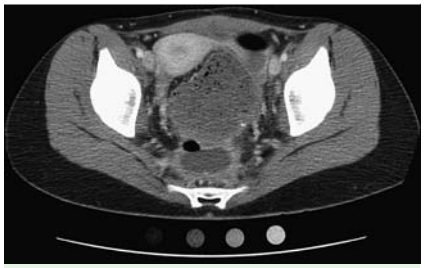

Fig. 1 Computed tomography (CT) of the pelvis, revealing a 5 × 3-cm pelvic abscess in a patient with J-pouch anatomy.

Fig. 2 Endoscopic ultrasound (EUS) image: the abscess cavity was punctured using a 19-gauge fine needle aspiration needle via the J-pouch under EUS guidance.

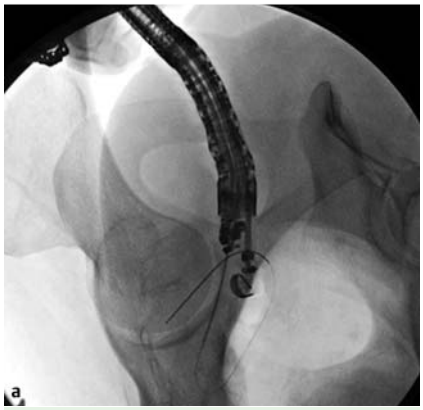

Fig. 3 **a** A 0.035-inch guidewire coiled within the abscess cavity under fluoroscopic guidance to facilitate sequential dilation. **b** Endoscopic view of the guidewire passed into the abscess cavity via the J-pouch.

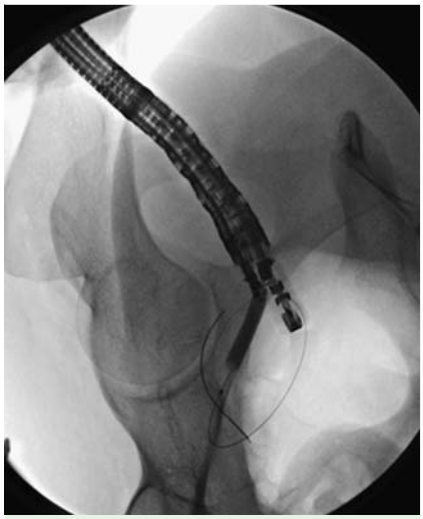

Fig. 4 Dilation of the transmural tract using a 6-mm over-the-wire balloon.

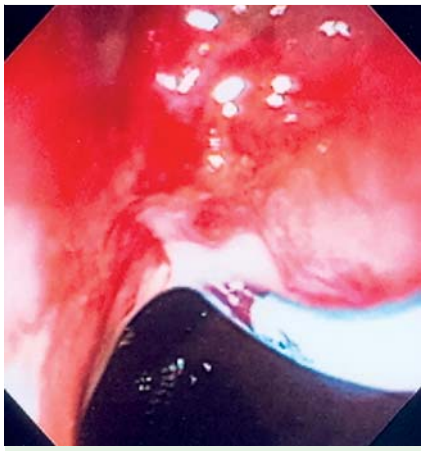

Fig. 5 Placement of a double pigtail stent into the abscess cavity via the J-pouch.

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. 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 guide wire was then coiled into the abscess (▶ **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.

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Competing interests: None

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Bibliography

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