A 51-year-old female with a complex urologic history was admitted to our institution with severe, lower midline abdominal pain radiating into the pelvis. She stated that the pain was reminiscent of the pain she experienced with prior bladder calculi. Her history was significant for epispadias status post multiple attempted reconstructions, which ultimately led to closure of the bladder neck and subsequent urinary bladder–ileum–sigmoid colon anastomosis. This produced a successful continent urinary diversion, but she experienced recurrent urinary tract infections and bladder calculi.

On computed tomographic scan of the abdomen and pelvis, a stone was observed in the bladder (Figure 1). Because of her complex surgical history and obesity, a nonsurgical means of stone removal was sought. A gastroenterology consultation was obtained for possible endoscopic removal.

In the operating room under general anesthesia and in the dorsal lithotomy position, a standard upper endoscope was used to perform a flexible sigmoidoscopy. In the distal sigmoid colon, the anastomosis was identified and dilated using a Microvasive® balloon (Boston Scientific, Natick, Massachusetts) over a guide wire (Figure 2 and Figure 3). The anastomosis was estimated to have a diameter of approximately 6 mm, and was subsequently dilated to 10 mm. Following dilation, the endoscope was advanced through the segment of ileum and into the bladder. In the bladder a 15-mm stone was identified and retrieved (Figure 4 and Figure 5) with a Roth® retrieval net (US Endoscopy, Mentor, Ohio). The patient tolerated the procedure well. At 4-month follow-up, the stone had not recurred.
tance of teamwork among specialists in the care of complex patients.

Endoscopy_UCTN_Code_CPL_1AJ_2AI
Endoscopy_UCTN_Code_TTT_1AQ_2AJ
Endoscopy_UCTN_Code_CCL_1AD_2AJ

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Endoscopy 2007; 39: E117–E118
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

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