Look both ways: gastrojejunocolic fistula masquerading as irritable bowel disease

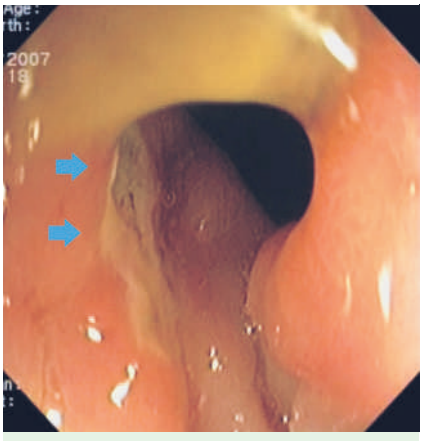

Fig. 1 Colonoscopy showing the opening of the fistula (transverse colon), with a chronic peptic ulcer at this level causing the diarrhea and hematochezia.

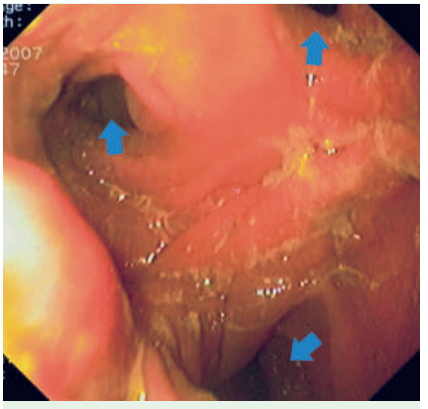

Fig. 3 Upper gastrointestinal endoscopy revealed the entrances into the duodenum (afferent loop), jejunum (efferent loop), and transverse colon (fistula tract).

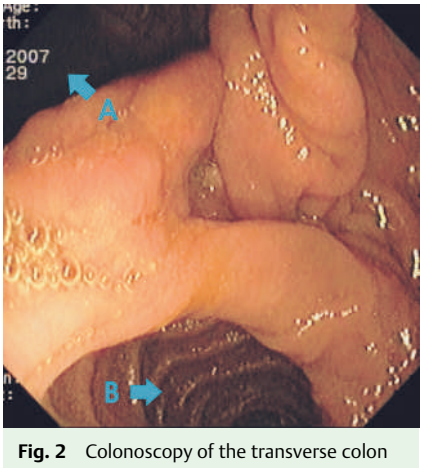

Fig. 2 Colonoscopy of the transverse colon with passage of the colonoscope through the fistula: entrance into the stomach (A) and jejunum (B).

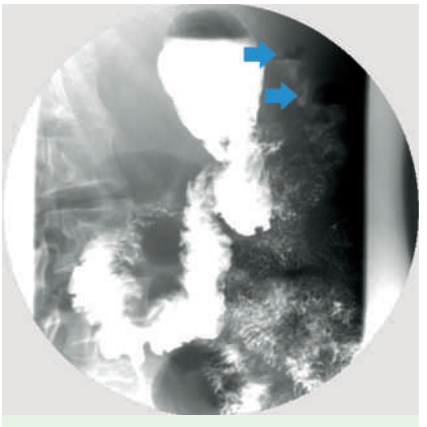

Fig. 4 Barium study of the stomach showed early passage of the contrast into the colon (visible horizontal air-fluid levels).

A 45-year-old patient was admitted to our department because of a history of diarrhea with red blood (hematochezia) and marked weight loss; all the symptoms had started about 6 months earlier. Physical examination revealed just a pale, emaciated patient with a surgical abdominal scar. The patient had undergone surgery for peptic ulcer disease 4 years previously. Because the current symptoms suggested inflammatory or malignant disease of the colon, the first imaging procedure performed was colonoscopy, during which the endoscope was able to pass abnormally, in the region of transverse colon, into another gut structure where the mucosal folds resembled those of the stomach. The passage was through a big fistula with a 3-cm ulcer with signs of recent bleeding (**Fig. 1**, **2**). Upper gastrointestinal endoscopy was further performed and visualized the partially resected stomach with a Billroth II gastroenteroanastomosis. Above the anastomosis, a big fistula was visible leading to the transverse colon (**Fig. 3**, **Video 1**). A barium study of the stomach was also performed, confirming the fistula with early presence of contrast inside the colon (**Fig. 4**). The patient was referred on to the surgery department where he was treated successfully, with conversion into a Roux-en-Y anastomosis. The further course was favorable, with complete recovery of the patient and no symptoms at 1-year follow-up.

Although barium enema is still considered the diagnostic investigation of choice for this condition, with a sensitivity of 95 – 100 % [1,2], in the present case the confusion with irritable bowel disease or even colorectal cancer dictated colonoscopy as first diagnostic procedure. Gastrojejunocolic fistula, although rare, is seen occasionally in current practice as a result of past gastric surgery [3]. However, such fistulas can also result from peptic ulcer disease, neoplasm, Crohn's disease, and infections [4]. Both gastroscopy and colonoscopy can be performed successfully in these patients, in order to establish the diagnosis and to define the

Video 1

Upper gastrointestinal endoscopy reveals the entrances into the duodenum (afferent loop), jejunum (efferent loop), and transverse colon (fistula tract).

precise location of the fistula before corrective surgery is carried out.

Endoscopy_UCTN_Code_CCL_1AB_2AZ_3AC
Endoscopy_UCTN_Code_CCL_1AD_2AD

D. I. Gheonea[1], A. Săftoiu[1], T. Ciurea[1], V. Şurlin[2], I. Georgescu[2]

[1] Department of Gastroenterology, Research Center in Gastroenterology and Hepatology, University of Medicine and Pharmacy Craiova, Romania

[2] Department of Surgery, Research Center in Gastroenterology and Hepatology, University of Medicine and Pharmacy Craiova, Romania

References

1 *Chung DP, Li RS, Leong HT.* Diagnosis and current management of gastrojejunocolic fistula. Hong Kong Med J 2001; 7: 439 – 441

2 *Ohta M, Konno H, Tanaka T et al.* Gastrojejunocolic fistula after gastrectomy with Billroth II reconstruction: report of a case. Surg Today 2002; 32: 367 – 370

3 *Herbella FA, Del GrandeJC, Beaton HL.* Surgical images: soft tissue. Postgastrectomy benign gastrojejunocolic fistula. Can J Surg 2007; 50: 397 – 398

4 *Malayil VT, Tony J, Harish K et al.* Simultaneous gastroscopy and colonoscopy for the diagnosis of gastrojejunocolic fistula. Gastrointest Endosc 2007; 66: 597 – 598

Bibliography

DOI 10.1055/s-2007-995768
Endoscopy 2008; 40: E145 – E146

ISSN 0013-726X

Corresponding author

D. I. Gheonea, MD
Research Center in Gastroenterology and Hepatology
University of Medicine and Pharmacy Craiova, Romania
1 Mai, 66
Craiova – 200638
Romania
Fax: +40-251-310287
digheonea@gmail.com