

Extended methods of enteroscopy

Single balloon enteroscopy (SBE) allows direct visualization of the small bowel and is important in the evaluation of covert gastrointestinal bleeding. The complication rate for double balloon enteroscopy is 1%. Complications include acute pancreatitis, perforation, and bleeding [1,2]. There are no published data of bacteremia following double balloon enteroscopy.

A 57-year-old gentleman was admitted with anemia and extensive hemochezia. History included hepatojejunostomy for biliary obstruction secondary to alcohol-induced chronic pancreatitis. He had noncirrhotic portal hypertension.

During his admission he required 39 units of blood. Identification of the bleeding source proved difficult despite esophago-gastroduodenoscopy, colonoscopy, and video capsule endoscopy. Radiological imaging demonstrated varices at the hepatojejunostomy anastomosis and porta hepatis (choledochal varices). The patient underwent SBE (● Fig. 1). The procedure was uncomplicated and no abnormality was demonstrated. However, 24 hours later he developed clinically significant *Streptococcus milleri* bacteremia. Antibiotic treatment was commenced and he made an uneventful recovery. No other potential source of the bacteremia was identified.

Humans and animals are hosts for Group C and G streptococci species. They are part of the normal skin, oral cavity, gastrointestinal, and vaginal flora. Patients infected with these streptococci typically include the elderly, men (who are more than twice as likely as women to become infected), and immunocompromised patients. Other risk factors include the post-operative period and animal product exposure [3].

Bacteremia of these phenotypes is associated with a mucosal breach. Identification is only possible through culture of pathognomic species [4]. Bacterial complications following endoscopic procedures are rare but may include liver or cerebral abscesses [5]. The incidence of these complications may increase, however, as current guidelines have removed antibiotic prophylaxis prior to procedures, even in high-risk individuals.

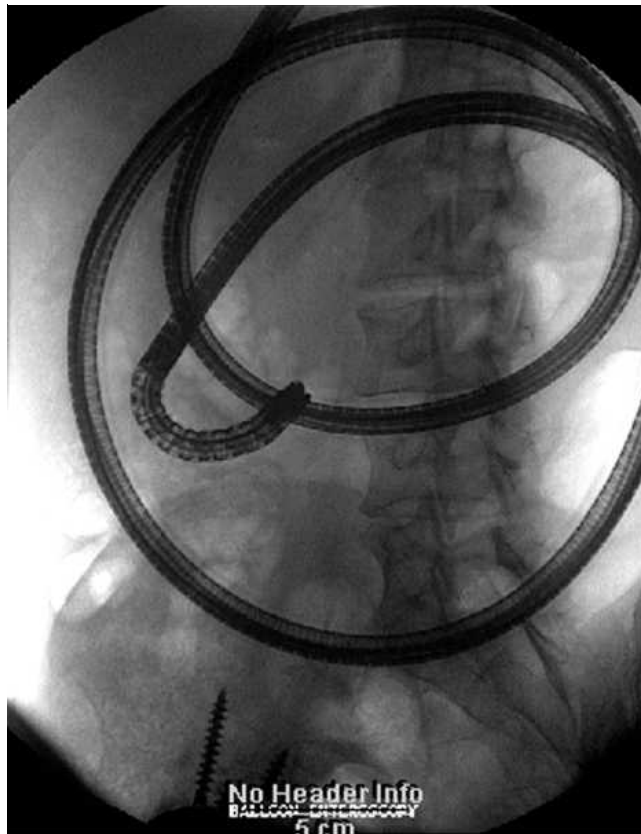


Fig. 1 Check radiograph of the endoscope during the enteroscopic procedure.

In the case illustrated here, the portal of entry was mucosal trauma during the enteroscopic procedure. The risk of bacterial translocation following SBE in patients with portal hypertension should be highlighted, and thus antibiotic prophylaxis considered prior to SBE.

Endoscopy_UCTN_Code_CPL_1AI_2AD

M. J. Austin, A. L. Rivett, S. Anderson
Department of Gastroenterology,
St Thomas' Hospital, London, UK

References

- 1 Vargo JJ, Upchurch B, Dumot JA *et al*. Clinical utility of the Olympus single balloon enteroscope: the initial US experience. *Gastrointest Endosc* 2007; 65: AB90
- 2 Mensink P, Haringsma J, Kucharzik TF *et al*. Complications of double balloon enteroscopy: a multicenter survey. *Gastrointest Endosc* 2007; 39: 613–615
- 3 Skogberg K, Simonen H, Renkonen OV, Valtonen VV. Beta-haemolytic group A, B, C and G streptococcal septicaemia: a clinical study. *Scand J Infect Dis* 1988; 20: 119–125

- 4 Ruoff KL. *Streptococcus anginosus* ("Streptococcus milleri"): the unrecognized pathogen. *Clin Microbiol Rev* 1988; 1: 102–108
- 5 Djupesland P, Solgaard T, Mair IWS. Cerebral abscess complicating dilatation of esophageal stricture. *Eur Arch Otorhinolaryngol* 1991; 248: 308–310

Bibliography

DOI 10.1055/s-2008-1077544

Endoscopy 2008; 40: E246

© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author

M. J. Austin, MRCP (UK)

Department of Gastroenterology

St Thomas' Hospital

London

SE1 7EH

UK

Fax: +44-207-1882484

mark.austin@gstt.nhs.uk