

Retrograde enteroclysis by double balloon enteroscopy in a patient with blunt abdominal trauma: small bowel stricture, intraluminal vascular lesion and Crohn's disease

Keywords: Constriction. Crohn's disease. Small intestine. Abdominal injury. Double balloon enteroscopy. Enteroclysis. Ischemic colitis. Cavernous hemangioma.

Dear Editor,

A 40-year-old male presented to the Emergency Department after a driving accident with blunt abdominal trauma. An abdominal computed tomography (CT) scan revealed a mesenteric injury in the right lower quadrant. He was admitted two months later due to a one-day history of abdominal pain and diarrhea, without fever or blood. The CT angiography showed a pseudoaneurysm located in the proximal ileum and several rigid small bowel (SB) loops with segmental wall thickening of mucosa (Fig. 1A).

An anal double-balloon enteroscopy (DBE) (3.2 mm large channel) was performed and revealed a severe ulcerated stricture (Fig. 1B), approximately 40 cm of ileocecal valve. The area was biopsied and tattooed. The endoscope could not pass beyond that point, so hydrosoluble contrast media and carbon dioxide were instilled via enteroscopy (retrograde enteroclysis) (Fig. 1C). A 5 cm stenotic ileum loop and a proximal mobile intraluminal lesion congruent with a pedunculated polyp was identified. The histopathology report of the SB biopsies showed non-specific ileitis without granulomas. The patient underwent a laparoscopic resection of the ileal segment with a primary anastomosis. The histopathological diagnosis was pedunculated cavernous hemangioma and Crohn's disease (CD).

Discussion

SB injuries from blunt abdominal trauma are uncommon (1-5%) (1,2). Sometimes, ischemic lesions of the digestive

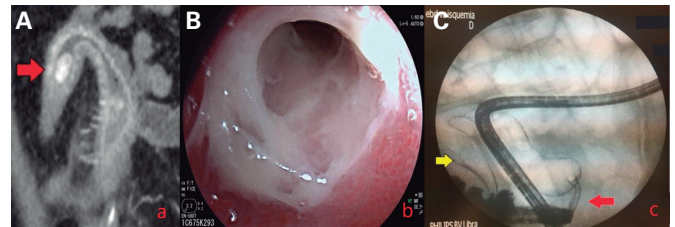


Fig. 1. A. CT angiography of the abdomen and pelvis. Coronal plane. A pseudoaneurysm like lesion (arrow). B. Double balloon enteroscopy. Ileum with a severe stricture. C. Enteroclysis with double balloon enteroscopy. A 5 cm stenotic ileum loop (red arrow) and distal pedunculated polyp (yellow arrow).

tract after a trauma occur over another disease that was not suspected until then (3). DBE allows the entire of the SB to be accessed and also offers the combination of enteroclysis and tattooing that can help to find the lesion during laparoscopy. Endoscopic evaluation with biopsies remains the major diagnostic tool for all patients with suspected ischemic enteritis or CD. However, the diagnostic efficiency is limited due to the transmural nature of CD, as well the absence of specific histopathological features (3,4).

Alejandro Pérez Fernández¹, Gloria Palomares Ortiz²
and Enrique Pérez-Cuadrado Martínez¹

¹Gastroenterology Section and ²General and Digestive Surgery Service. Hospital General Universitario Morales Meseguer. Murcia, Spain

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