

Letters to the Editor

Endoscopic treatment with diathermy of ileorectal anastomotic stricture

Key words: Endoscopy. Electrocoagulation. Pathologic. Anastomosis. Surgical.

Dear Editor,

Anastomotic strictures are a frequent complication of surgery, especially in those performed with staplers, such as conventional rectal surgeries.

We describe the endoscopic use of electrocautery assisted with balloon dilatation for ileorectal anastomotic stenosis.

Case report

The patient was a 22-year-old woman with a history of familial adenomatous polyposis, who underwent total colectomy in 2009 with a 25 gauge stapled side-to-end ileorectal anastomosis that was placed 12 cm from the anal verge. Seven months after the intervention, an anastomotic stricture developed and conventional balloon dilatation treatment was used. The stricture was impenetrable with the endoscope. More than twelve dilatations were attempted without success. Although this treatment allowed dilatation up to 18 mm in width, early recurrence caused us to seek alternative treatment options.

We proposed performing radial incisions with electrocautery, which included the use of a sphincterotome with a needle, aided by balloon dilatations. To determine if this was the proper technique, we evaluated the anastomosis, our previous experience in the treatment of gastroesophageal strictures

secondary to esophageal neoplasia, and the lack of experience in the management of biodegradable prosthesis. We also evaluated the use of self-expanding metal prostheses, which are not without risks.

The technique was successful; we made 6 incisions ("star" incision) 3 mm in depth to minimize risk of perforation. After the incisions were performed and the appropriate diameter reached, we dilated the balloon from 15-18 mm to 18-20 mm. Finally, we injected 40 mg of triamcinolone, increasing from 9 mm to 20 mm in the same session. The model of the sphincterotome we used was RX Needle Knife XL 5.5 F with a needle length of 5 mm (Boston Scientific®). The source used was the diathermy ERBE ICC 200, endocut current, power effect 3 and 60 W (Fig. 1).

After 1 year of incisional therapy, we found that the gauge had not decreased.



Fig. 1. Anastomotic stricture with electrocautery eschar.

Discussion

The prevalence of anastomotic strictures is up to 20 % (1) and their origin is uncertain but they are used to be secondary to a complication of anastomosis dehiscence or ischemia (2). Occasionally, conventional treatment by balloon dilatation or stents is ineffective.

The use of electrocautery to break the fibrosis, which causes the stenosis, has been described as safe and effective (2-5). Despite this, its use is not widespread. Instead, dilatation treatment is exclusively used for both colorectal and esophageal anastomosis.

While not completely free of complications, we would like to emphasize the importance of this technique because of its effectiveness and safety.

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