A 65-year-old man presented to the outpatient department with a complaint of moderate flatulence for 2 years. His personal history included coronary artery disease and type 2 diabetes mellitus, which was poorly controlled by oral anti-diabetic medications. He also underwent inguinal hernia operation 2 years previously.

Physical examination revealed no pathologic signs. Vital signs were within normal limits. Laboratory tests showed no abnormal values except high fasting blood sugar level. After colonic preparation with polyethylene glycol solution, colonoscopy was performed.

The sigmoid colon contained multiple polypoid cystic structures (Fig. 1). The colonic section with these extensive lesions was filled with water. Polypoid cystic structures were punctured using a sclerotherapy needle under water. The emergence of gas bubbles from punctured sites was seen (Fig. 2, Video 1). Preliminary diagnosis of pneumatosis intestinalis was considered. Subsequent computed tomography revealed intramural gas collections in the wall of the sigmoid colon.

In etiological investigation tests, chest X-ray and respiratory function tests were normal. Antinuclear antibodies and extractable nuclear antigen antibodies were found to be nonreactive. Direct examination, culture, and parasite tests of stool were negative. Rapid Detection of Clostridium difficile in feces by real-time polymerase chain reaction turned out to be negative too. Hence, we considered our case to be idiopathic.

Pneumatosis intestinalis is a rare disease, the clinic symptoms of which may be asymptomatic or serious enough to be a case of acute abdomen. Depending on different etiologies, it can occur in two forms – primary (idiopathic) or secondary. Diagnosis is often made with radiologic or endoscopic imaging. We presented a case that was diagnosed endoscopically with water-immersion technique and puncture.

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Competing interests

None