A previously healthy 21-year-old woman without a history suggesting stenosis and normal ileocolonoscopic findings underwent wireless capsule endoscopy (PillCam SB 11 × 26 mm; Given Imaging, Yoqneam, Israel) for suspected Crohn’s disease of the small bowel. Approximately 16 hours after capsule intake, she developed small-bowel ileus (\textit{Fig. 1}). The capsule recording showed skip lesions of inflamed small bowel with ulcerations, swelling, pseudopolyps, and stenosis (\textit{Fig. 2}). After 6.5 hours, capsule progression was halted by a strictured small-bowel segment with severely active disease (\textit{Fig. 3}). A diagnosis of severe stenosing Crohn’s disease of the small bowel with subsequent capsule retention leading to obstruction of the small bowel was made.

After consultation with the surgeons it was decided to try to induce reduction of the swelling and stenosis medically. Three hours after onset of symptoms, 200 mg hydrocortisone and 300 mg infliximab were administered. Six hours later the patient felt much better. A new abdominal exam indicated that the capsule had progressed into the sigmoid colon (\textit{Fig. 4}). Capsule endoscopy has rapidly become the procedure of choice for evaluation of suspected small-bowel Crohn’s disease because of its safety and high diagnostic yield, in particular when ileocolonoscopy is negative [1]. Capsule retention proximal to a stenosis is the most important complication but is rare [2, 3]. Treatment usually consists of endoscopic or surgical intervention with simultaneous treatment of the stenosis. If a stenosis is suspected, small-bowel radiography has to be done first [3, 4]. Alternatively, the “patency” capsule may be used, but reports on its efficacy are equivocal [5].

We conclude that immediate treatment with immunosuppressive medication to reduce swelling and stenosis should be considered in acute cases of capsule retention if a diagnosis of Crohn’s disease can be established on the basis of the images made by the obstructing capsule. In this way surgery can be avoided or at least postponed, and at the same time treatment of the underlying disease is initiated.
L. Vanfleteren, P. van der Schaar, J. Goedhard
Department of Gastroenterology and Hepatology, Atrium Medical Center, Heerlen, The Netherlands

References


Bibliography
Endoscopy 2009; 41: E134 –E135
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author
L. Vanfleteren, MD
Department of Gastroenterology and Hepatology
Atrium Medical Center
Henry Dunant straat 5
Postbus 4446
6401 CX Heerlen
The Netherlands
lowievanfleteren@gmail.com