While prior reports have demonstrated the usefulness of endoscopic ultrasound (EUS) for transrectal drainage of pelvic abscesses, its utility for performing drainage via an ileoanal reservoir (J-pouch) has not been reported before.

A 28-year-old patient with a history of total colectomy and a J-pouch for ulcerative colitis presented with persistent fever and rectal pain. Computed tomography (CT) of the pelvis revealed an abscess measuring 5 × 3 cm adjacent to the J-pouch (Fig. 1). EUS-guided drainage of the abscess was requested because of the lack of an adequate window for percutaneous drainage. At EUS, the pelvic abscess was punctured (Fig. 2) using a 19-gauge fine needle aspiration needle via the J-pouch under EUS guidance.

EUS-guided drainage of the abscess was requested because of the lack of an adequate window for percutaneous drainage. At EUS, the pelvic abscess was punctured (Fig. 2) using a 19-gauge fine needle aspiration needle (Expect; Boston Scientific, Natick, Massachusetts, USA), and a 0.035-inch guide wire was then coiled into the abscess (Fig. 3) under fluoroscopic guidance. The transmural tract was sequentially dilated using a 5-Fr endoscopic retrograde cholangiopancreatography cannula and a 6-mm balloon dilator (Fig. 4). A 7-Fr double pigtail stent was then deployed into the abscess cavity (Fig. 5).

Postprocedure, the patient was afebrile and had no rectal pain. Follow-up CT revealed complete resolution of the abscess, and so the transrectal stent was retrieved by sigmoidoscopy.

Fitting a J-pouch, sometimes referred to as ileoanal reservoir, involves colectomy and mucosal proctectomy and the creation of an ileal reservoir which is anastomosed to the anal canal [1]. In a meta-analysis, 9.5% of patients with a J-pouch developed pelvic abscess from anastomotic dehiscence [2]. Initial management often includes percutaneous drainage; a persistent abscess may require surgery [3]. In a prior study by myself and a co-author, we have shown that EUS is a minimally invasive alternative for drainage of pelvic abscesses [4]. However, patients with a J-pouch were excluded because of concerns of perforation in a surgically constructed anatomy. Given the inability to treat the pelvic abscess by percutaneous means, we attempted drainage via the J-pouch in this patient, with good clinical outcomes.

Endoscopy_UCTN_Code_TTT_1AS_2AZ

**Competing interests:** None
S. Varadarajulu  
University of Alabama at Birmingham  
School of Medicine, Birmingham, Alabama, USA

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Endoscopy 2012; 44: E92–E93  
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author
S. Varadarajulu, MD  
Basil I. Hirschowitz Endoscopic Center of Excellence  
University of Alabama at Birmingham  
School of Medicine  
JT 664, 1530 3rd Avenue South  
Birmingham  
Alabama 35294  
USA  
Fax: +1-205-975-6381  
svaradarajulu@yahoo.com