Transrectal endoscopic ultrasound-guided drainage of pelvic abscess with placement of a fully covered self-expandable metal stent

Pelvic abscess developed in an 88-year-old woman (Case 1) following a Hartmann’s procedure for a perforated diverticulum and in a 78-year-old woman (Case 2) after diverticulitis. Conservative management was unsuccessful in the first patient due to advanced age and in the second patient due to severe co-morbidities.

Both patients underwent transrectal endoscopic ultrasound (EUS)-guided drainage of the pelvic abscess using the same technique, with placement of a transmural fully covered self-expandable metal stent (SEMS). Briefly, a 19-gauge needle was introduced into the collection using a linear echoendoscope. A 0.035-inch wire was then positioned in the cavity and a pre-cut needle-knife was used to create a fistula. A 10 × 40 mm fully covered SEMS (WallFlex; Microvasive Endoscopy, Boston Scientific Corp., Natick, Massachusetts, USA) was then placed over the guide wire.

After the procedure, the patients improved substantially and were discharged home after 5 and 6 days, respectively. In both patients, computed tomography (CT) of the pelvis 2 weeks later showed resolution of the abscess. The fully covered SEMSs were then removed by rectoscopy a week later.

A follow-up CT 1 month later revealed complete resolution of the abscess in both patients without recurrence. Recently, EUS-guided drainage has been proposed as a minimally invasive alternative for the drainage of pelvic abscesses. Taking into account the available published data, a drainage catheter and one or two plastic stents for each lesion seem to be the best endoscopic approach. Fully covered SEMSs have also recently been adopted for the drainage of infected pancreatic fluid collections with good results.

To the best of our knowledge, these are the first two cases of a fully covered SEMS used for transrectal EUS-guided drainage of pelvic abscesses. We think that the use of these stents can give good results for the drainage of pelvic abscesses.

Competing interests: None
References

2 Trevino JM, Drelichman ER, Varadarajulu S. Modified technique for EUS-guided drainage of pelvic abscess (with video). Gastrointest Endosc 2008; 68: 1215–1219
3 Varadarajulu S, Drelichman ER. Effectiveness of EUS in drainage of pelvic abscesses in 25 consecutive patients (with video). Gastrointest Endosc 2009; 70: 1121–1127

Bibliography

DOI http://dx.doi.org/10.1055/s-0032-1326250
Endoscopy 2013; 45: E245–E246
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author

C. Fabbri, MD
Unit of Gastroenterology and Digestive Endoscopy
AUSL Bologna
Bellaria Hospital
Via Altura
40139 Bologna
Italy
Fax: +39-051-6225247
carlo.fabbri@ausl.bologna.it

Fig. 2 Computed tomography 2 weeks after drainage, showing resolution of the abscess with transrectal stents visible within the abscess cavity and rectum.

Case 1. Case 2.

Fig. 3 Computed tomography 1 month after stent removal showing resolution without recurrence of the pelvic abscess.

Case 1. Case 2.