

Over-the-scope-clipping in colonic perforation caused small-bowel fixation and pneumoperitoneum requiring surgical repair

Perforations during endoscopy can be treated using through-the-scope clips or the over-the-scope clip (OTSC) [1–3]. The rate of successful perforation closure using the OTSC has been reported to be approximately 89% with an acceptable morbidity and mortality rate of 3% [3,4]. Nevertheless, this method may also entail some risks, as shown here in a 62-year-old man who was referred for colonoscopy because of abdominal pain and melena. During diagnostic colonoscopy a 3-mm perforation ostium was noticed in the sigmoid (Fig. 1). The colonoscope was withdrawn and an OTSC (OTSC System Set 11/6 a; Ovesco, Tübingen, Germany) was then applied via suction to the colonic wall and the ostium of the perforation. The ostium was placed directly within the cap of the OTSC and the defect appeared to be completely closed (Fig. 2 and Fig. 3). However, a polypoid intraluminal yellowish structure was noticed and was interpreted as mesenteric fat (Fig. 4). Abdominal pain occurred post-interventionally and a radiograph showed free intra-abdominal air. At abdominal computed tomography (CT) the small intestine appeared to be fixed to the colon, and along the right edge a substantial amount of air and fluid was noticed near the colon. Sigmoid resection was performed immediately with creation of a descendostomy (outlet from the descending colon) and blind closure of the rectum. Intraoperatively, the small intestine was found to be tightly fixed to the colon and showed signs of strong tension. Also, surprisingly, a consequent small-bowel perforation was found and this was sutured. Histopathological examination showed a fresh transmural wall defect in the sigmoid colon with hemorrhage and local peritonitis. Although the successful use of the OTSC has been described for many indications [1–6], this case demonstrates a major adverse effect of OTSC application. The sucking of mobile small intestine towards the ostium of the colonic perforation, brought about the previously unreported occurrence of inadvertent fixation of the small

intestine to the colon with subsequent perforation of the small bowel. Possibly, a slower closure of the perforation using the “Twin Grasper” or the “OTSC Anchor,” rather than the fast method using strong suction only that was applied in this case, would have avoided this major complication. Therefore, in colonic perforations separate approximation of each wound edge, using the “Twin Grasper” with good visualization, is warranted before release of the OTSC.

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Competing interests: None

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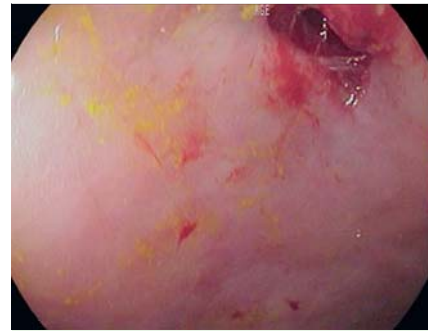


Fig. 1 A 3-mm perforation was seen in the sigmoid colon.

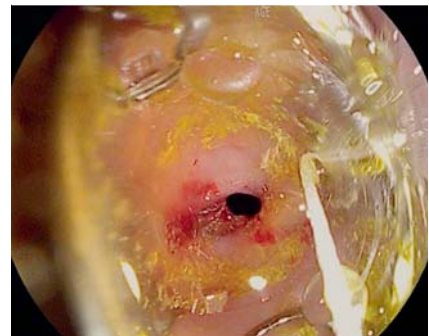


Fig. 2 The perforation was positioned within the cap of the over-the-scope clip (OTSC).



Fig. 3 Complete closure of the colonic perforation with the over-the-scope clip (OTSC).



Fig. 4 A polypoid intraluminal yellowish structure was seen after closure of the colonic perforation with the over-the-scope clip (OTSC).

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Bibliography

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