The procedure, an abdominal plain film showed subphrenic gas, consistent with an intestinal perforation (Fig. 2a). He had no signs of acute peritonitis, but had a low grade fever for 2 days so received intravenous antibiotics. A repeat abdominal plain film 1 week later revealed absence of the subphrenic gas (Fig. 2b), indicating that the perforation had been successfully closed.

He was eventually diagnosed with Crohn’s disease and was discharged home with oral methylprednisolone and azathioprine. His symptoms resolved and capsule endoscopy 6 months later revealed improvement of the lesions and absence of the perforation.

Surgical management is the first-line treatment of intestinal perforation [1,2]; however, it is an invasive method with a high risk of complications, even mortality, and recurrence is a common concern for patients with Crohn’s disease. Closure of a perforation with an autologous fat plug has been performed in the stomach and colon, and has shown promising results [3–5]. In the present patient, intestinal perforation was encountered during DBE and was successfully closed with an autologous fat plug, which prevented the patient from needing surgery with its associated morbidity. To the best of our knowledge, this is the first report of iatrogenic intestinal perforation in a patient with Crohn’s disease that was managed by autologous fat plug closure.

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