An 82-year-old female developed cervical emphysema and acute abdomen 7 hours following an otherwise normal diagnostic colonoscopy. Abdominal radiograph (Fig. 1 a) disclosed the presence of air along the borders of both iliopecto musles. As the possiblity of intraperitoneal colonic perforation could not be excluded, she was submitted to exploratory laparotomy; sigmoid diverticuli, without any evidence of colonic perforation, purulent or fecal peritonitis, were found. However, air trapped into the retroperitoneum forming multiple characteristic bubbles, was disclosed (Fig. 1 b). The posterior peritoneum was bluntly dissected.

A 62-year-old female developed subcutaneous emphysema on her neck, face, lateral abdominal wall, and right upper limb, 15 minutes after a diagnostic colonoscopy, which disclosed a small orifice 15 cm from the anal verge (Fig. 2 a). Abdominal radiograph (Fig. 2 b) disclosed the presence of air along the left colon and under both hemi-diaphragms, while a linear presence of air at the level of the rectosigmoid junction, probably indicated the exact site of the air leak. Chest radiograph (Fig. 2 c) disclosed pneumomediastinum and pneumopericardium, while upper abdominal computed tomography scan (Fig. 2 d) disclosed retroperitoneal air accumulation behind the pleura. The patient was treated conservatively.

The term “silent perforation” [1] has been used to explain the rare complication of retroperitoneal accumulation of the air in the absence of acute clinical signs, following colonoscopy. Accumulation of air into the retroperitoneum is favored by the pressure gradient between the intraluminal colonic pressure (60 cm H$_2$O) caused by the peristaltic waves and the pressure in the soft tissues (5 cm H$_2$O) [2]. Once air enters the retroperitoneum, it can be transferred either into the peritoneal cavity or into the visceral space [3], forming retroperitoneal emphysema, pneumatosis cystoides intestinalis, pneumomediastinum, pneumothorax or subcutaneous emphysema [3]. Propagation of the retroperitoneal air either through the visceral space to the periphery along the great vessels of the neck or through the esophageal hiatus to the mediastinum and then to the soft tissues of the neck [4], can explain the cervical emphysema development. In the absence of intraperitoneal air accumulation, acute abdomen can be explained by the distension of the retroperitoneal fascia second-
ary to the trapped air, exacerbating visceral and somatic pain [5]. Conservative management seems effective, reserving surgery for complicated cases.

References

Bibliography
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