A 79-year-old man presented with a 2-month history of abdominal pain. Computed tomography (CT) showed an abdominal tumor, peritoneal dissemination, and ascites (Fig. 1). Total colonoscopy, including observation of the terminal ileum and esophagogastroduodenoscopy, showed no specific findings. However, because of abnormal radiographic findings of the jejunum, a single-balloon enteroscopy was performed via the anterograde approach using an enteroscope (SIF-Q260; Olympus, Tokyo, Japan) with a flexible overtube (ST-SB1; Olympus) [1, 2]. The patient was sedated with midazolam (10 mg IV) but complained of abdominal pain during insertion of the endoscope into the jejunum. Perforation was suspected under fluoroscopy before the endoscope had encountered any lesions. The enteroscope was withdrawn and abdominal radiograph and CT scan suggested intestinal perforation (Fig. 2). The small intestine was partially resected because the site of the perforation had been confirmed during the laparotomy. Multiple whitish tumors had metastasized mainly to the serosa of the intestine and peritoneum. Gross pathological examination revealed that metastatic tumors had invaded from the serosa into the mucosa and created multiple ulcers, one of which was perforated (Fig. 3). Histology of the site of perforation revealed a diffuse infiltrate of tumor cells involving all layers of the small intestinal wall (Fig. 4). Although the tumors were diagnosed as metastatic carcinoma by further immunohistochemical examination, a diagnosis of metastatic carcinoma of unknown origin was made because further clinical investigations could not confirm the primary site of the carcinoma.

Forceful distention and traction may predispose to perforation of an already weakened small intestinal wall; therefore, if fragile lesions are encountered, insertion of the endoscope beyond the lesions is not recommended [3, 4]. However, in our case, perforation occurred before the endoscope had encountered the lesions. Although it may be difficult to prevent such problems, care must be taken when using an endoscope in the small intestines.
intestine.

Endoscopy_UCTN_Code_CPL_1AI_2AD

K. Tominaga1, T. Iida1, Y. Nakamura2, J. Nagao2, Y. Yokouchi1, I. Maetani1

1 Division of Gastroenterology, Department of Internal Medicine, Toho University Ohashi Medical Center, Tokyo, Japan

2 Third Department of Surgery, Toho University Ohashi Medical Center, Tokyo, Japan

3 Department of Surgical Pathology, Toho University Ohashi Medical Center, Tokyo, Japan

References


Bibliography


Endoscopy 2008; 40: E213 – E214

© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author

K. Tominaga, MD
Division of Gastroenterology
Department of Internal Medicine
Toho University Ohashi Medical Center
2-17-6 Ohashi
Meguro-ku
Tokyo 153-8515
Japan

Fax: 81-3-3468-1269
ktominaga@oha.toho-u.ac.jp

Fig. 4 Histological analysis of the site of perforation of the tumor ulcer. A diffuse infiltrate of tumor cells involving all layers of the small intestinal wall can be seen (hematoxylin and eosin, original magnification × 4).