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WJGS covers topics concerning micro-invasive surgery; laparoscopy; hepatic, biliary, pancreatic and splenic surgery; surgical nutrition; portal hypertension, as well as associated subjects. The current columns of *WJGS* include editorial, frontier, diagnostic advances, therapeutics advances, field of vision, mini-reviews, review, topic highlight, medical ethics, original articles, case report, clinical case conference (Clinicopathological conference), and autobiography. Priority publication will be given to articles concerning diagnosis and treatment of gastrointestinal surgery diseases. The following aspects are covered: Clinical diagnosis, laboratory diagnosis, differential diagnosis, imaging tests, pathological diagnosis, molecular biological diagnosis, immunological diagnosis, genetic diagnosis, functional diagnostics, and physical diagnosis; and comprehensive therapy, drug therapy, surgical therapy, interventional treatment, minimally invasive therapy, and robot-assisted therapy.

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Retrospective Study

Results of the open surgery after endoscopic basket impaction during ERCP procedure

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Abstract

AIM: To report the results of open surgery for patients with basket impaction during endoscopic retrograde cholangiopancreatography (ERCP) procedure.

METHODS: Basket impaction of either classical Dormia basket or mechanical lithotripter basket with an entrapped stone occurred in six patients. These patients were immediately operated for removal of stone(s) and impacted basket. The postoperative course, length of hospital stay, diameter of the stone, complication and the surgical procedure of the patients were reported retrospectively.

RESULTS: Six patients (M/F, 0/6) were operated due to impacted basket during ERCP procedure. The mean age of the patients was 64.33 ± 14.41 years. In all cases the surgery was performed immediately after the failed ERCP procedure by making a right

subcostal incision. The baskets containing the stone were removed through longitudinal choledochotomy with the stone. The choledochotomy incisions were closed by primary closure in four patients and T tube placement in two patients. All patients were also performed cholecystectomy additionally since they had cholelithiasis. In patients with T-tube placement it was removed on the 13th day after a normal T-tube cholangiogram. The patients remained stable at postoperative period and discharged without any complication at median 7 d.

CONCLUSION: Open surgical procedures can be applied in patients with basket impaction during ERCP procedure in selected cases.

Key words: Biliary stone; Endoscopic retrograde cholangiopancreatography; Basket; Impaction; Surgery

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Core tip: The impaction or wire fracture of basket is an uncommon but potentially highly dangerous complication during endoscopic retrograde cholangiopancreatography and stone extraction. Although there are several endoscopic approaches to treat the basket impaction they require specialized equipments and experienced clinicians. So surgical approach can be an alternative to endoscopic procedures in selected patients.

Yilmaz S, Ersen O, Ozkececi T, Turel KS, Kokulu S, Kacar E, Akici M, Cilekar M, Kavak O, Arikan Y. Results of the open surgery after endoscopic basket impaction during ERCP procedure. *World J Gastrointest Surg* 2015; 7(2): 15-20 Available from: URL: <http://www.wjgnet.com/1948-9366/full/v7/i2/15.htm> DOI: <http://dx.doi.org/10.4240/wjgs.v7.i2.15>

INTRODUCTION

Endoscopic retrograde cholangiopancreatography (ERCP) is mainly indicated for choledocholithiasis as well as pancreatic stones^[1,2]. It can be performed to remove the biliary stones when combined with sphincterotomy. Bile duct stones are successfully removed with classical Dormia basket or balloon catheters in 85%-95% of the patients^[3]. Mechanical lithotripsy is the second line method for non-extractable stones with conventional basket aside from availability and cost^[4,5]. Several types of baskets (mechanic lithotripter or wire baskets) can be used for this purpose^[6]. The success rates depend on several factors as size and number of the stones, degree of the jaundice and presence of cholecystitis. Complications of ERCP have been reported to occur in 5%-10% of the cases^[7]. Basket related complications can be seen as impaction around a calculus or fracture of the traction wire. Endoscopic

basket impaction is a rare and unusual complication that can be seen after an attempt for removal of biliary stones with basket. It is not encountered in classical ERCP complications in textbooks due to its extremely rare occurrence. Actually it is a problem of high volume centers. It is defined as inability to withdraw the basket with stone from papillary orifice or separate the stone from the basket in biliary channel lumen. Since there are only sporadic case reports, the precise treatment is still controversial^[8]. At present endoscopic or surgical procedures can be applied for the basket impaction. Non operative maneuvers like extracorporeal shock wave, intracorporeal electrohydraulic lithotripsy, catching the basket tip with a second basket, balloon dilatation of the sphincterotomy area or laser lithotripsy are recommended at high technology units^[9-11]. However these procedures require experienced endoscopists and sophisticated technological equipment. Therefore open surgery is still an alternative approach for such patients. In the present study, we reported the results of six patients with endoscopic basket impaction that have been treated with open surgery. To our best knowledge the present report is the largest series so far.

MATERIALS AND METHODS

Patients

This retrospective observational study was carried out between June 2008 and June 2014. A total of 1065 ERCP procedures were performed at our invasive endoscopic procedures unit for choledocholithiasis at this period. The total number of ERCP was 2092. Basket impaction of either classical Dormia basket or mechanical lithotripter basket with an entrapped stone were observed in six patients (0.28%). The mean age of the patients was 64.33 ± 14.41 years and they were all female. The patients were admitted with the right upper abdominal pain. Laboratory findings were consistent with cholestasis and obstructive jaundice. Ultrasonography and magnetic resonance cholangiopancreatography (MRCP) revealed one to seven pieces of biliary stones sizes ranging from 15 mm to 30 mm in diameter and dilated choledochus which had a diameter above 15 mm. A diagnosis of obstructive jaundice secondary to choledocholithiasis was made and the patients were proceeded to an ERCP with planned removal of biliary stone. The median age of our patients was 63 years (range 45-81 years). The perampullary diverticulum was present in four patients. In five patients, impacted basket was Dormia and in one impaction occurred with mechanical lithotripter basket. The clinical data and the endoscopic features of the patients are represented in Tables 1 and 2. All patients in the work gave informed consent for the study prior to manuscript preparation.

Table 1 Details of the patients characteristics

Case	Age	LOS	Comorbidity	Surgical procedure	Additional procedure	PO complication
1	59	7	HF	T-Tube placement	Cholecystectomy	None
2	54	8	None	Primary closure	Cholecystectomy	None
3	80	4	None	Primary closure	Cholecystectomy	None
4	67	3	None	Primary closure	Cholecystectomy	Atelectasis
5	81	7	COLD	T-Tube placement	Cholecystectomy	SSI
6	45	9	HT	Primary closure	Cholecystectomy	SSI

LOS: Length of hospital stay; PO: Postoperative; HF: Heart failure; HT: Hypertension; SSI: Surgical site infection; COLD: Chronic obstructive lung disease.

Table 2 Endoscopic features of the patients

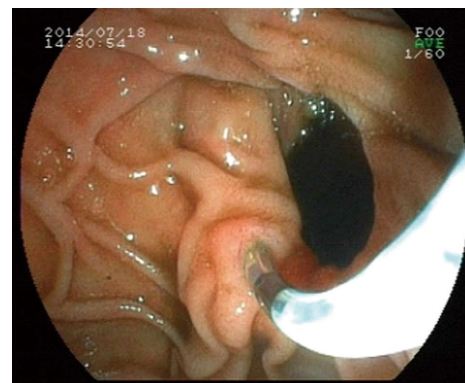
Case	Diameter of the choledochus (mm)	Maximum biliary stone size (mm)	No. of stones	Impaction type	Presence of diverticula
1	15	15	1	Dormia	Yes
2	20	20	3	Dormia	No
3	30	30	6	Litotripter	No
4	30	30	1	Dormia	Yes
5	25	20	7	Dormia	Yes
6	20	20	2	Dormia	Yes

Anaesthesia protocol and medication

All patients received fentanyl (1 µg/kg) before the procedure and a single dose of 0.04 mg/kg midazolam intravenously and additional doses of 0.5 mg midazolam until the Ramsey Sedation Score reached 3-4 points. We used the additional doses of midazolam to keep the consciousness to allow communication, while providing the necessary degree of sedation to enable surgical comfort and an adequate quality of recovery with no negative effects on haemodynamics and respiratory parameters. During procedure a routine antibiotic prophylaxis (*iv* cefazolin 1 g) was administered and duodenal peristalsis was reduced by *iv* hyoscine-n-butylbromide.

Endoscopic procedure

Endoscopic procedures and ensuing surgical procedures were performed by one of the three consultant surgeons themselves (SY, TO, YA). Following the demonstration and cannulation of the papilla, a cholangiography was obtained revealing the huge stone(s) (Figure 1). First conventional basket was tried to remove the stone from papilla (Figure 2). If it was unsuccessful and the stone could be separated from basket than basket was removed and mechanical lithotripter was placed to crush the stone(s). In both instances if the basket

**Figure 1** Cholangiography demonstrating the two giant sharp edged stones.**Figure 2** Cannulation through the papillary orifice located near to a big diverticula.

stone complex couldn't be pulled out papillary orifice despite forceful traction or basket couldn't be disengaged from the stone, the diagnosis of basket impaction was verified (Figure 3). The basket impaction occurred within the intraduodenal portion of the choledochus in all patients. In this instance the handle site of basket wire was cut with Kirshner cutter, duodenoscope was removed and the patient was transferred to operating room with distal end of the basket emerging from the mouth (Figure 4). In all cases the surgery was performed immediately after the failed ERCP procedure by making a right subcostal incision. The baskets containing the stone were removed through longitudinal choledochotomy (Figure 5). The choledochotomy incisions were closed by primary closure in four patients and T tube placement in two patients. All patients were also performed cholecystectomy additionally since they had cholelithiasis. In patients with T-tube placement it was removed on the 13th day after a normal T-tube cholangiogram. The patients remained stable at postoperative period and discharged without any complication at median 7 d.

Statistical analysis

Since the present study is a retrospective descript

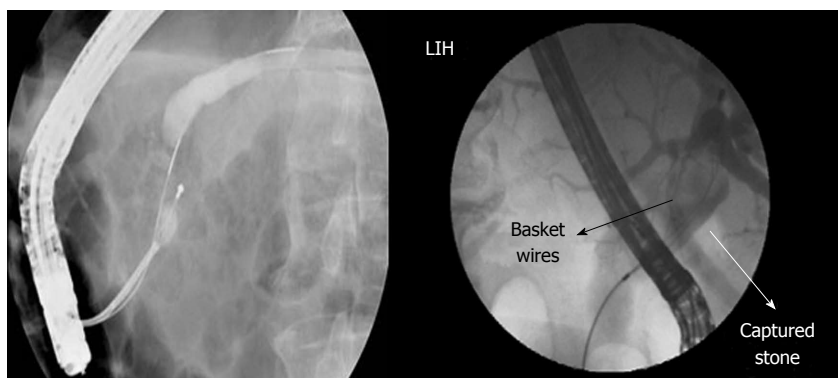


Figure 3 Basket attempts with Dormia to remove the angled (right) and round (left) stones.



Figure 4 Following a failed removal of a stone, the transfer of the patient to the operating room while the cut edge of basket handle emerging from the mouth immediately after the procedure.



Figure 5 Removal of the entrapped basket and stone complex through a longitudinal choledochotomy incision.

study, we didn't perform any Statistical evaluation.

DISCUSSION

ERCP is an important endoscopic procedure with more than 500000 procedures performed yearly in the United States^[7]. Although the precise number in our country is not known, we are performing approximately 300 procedures annually in our centre. Nearly half of these are due to biliary stones. ERCP, sphincterotomy and stone extraction are currently the best method to remove the stones in biliary system^[12]. There are several complications including bleeding, perforation sepsis, pancreatitis and cholangitis following ERCP.

Endoscopy clinicians who perform more than 200 ERCP procedures per year (high volume centre) have been shown to have fewer complications than less experienced endoscopists who perform < 200 ERCPs per year^[7]. There are several kinds of baskets made from metal wires and available in a variety of sizes and configurations to remove the biliary stones. Basket impaction is relatively rare but potentially quite dangerous complication during ERCP procedure. So far Katsinelos *et al*^[13] reported the largest series of basket impaction that is the seven cases within 2715 ERCP procedures^[13]. They treated such cases with endoscopic approach in six cases and one case was managed successfully with

surgery. In the present study we reported the results of open surgery in six patients with basket impaction out of 2092 ERCP procedures between June 2008-June 2014. The incidence is approximately 0.28% that is quite similar to the rate observed in previous case series (0.26%). Although the incidence is very low, impaction of a basket with an entrapped stone may cause cholangitis, pancreatitis, sepsis and even death, thereby usually requiring open surgery or other specialized endoscopic techniques^[12,14,15]. However endoscopic "rescue" interventions mostly require skilled experience and sophisticated endoscopic devices that are not widely available in many endoscopy centres. Additionally failed efforts may deteriorate the patient's clinical condition and even lead to perforation, hemorrhage and severe inflammation around the papilla that make an eventual open surgery more complicated. It can be seen both after conventional Dormia basket or mechanical lithotripter basket usage. Dormia basket may fail in the presence of large stone, in which case mechanical lithotripsy should be the latter choice in the treatment of choledocholithiasis. Mechanical lithotripter is able to crush the biliary stones into pieces so they can be taken out from the papillary orifice with conventional basket easily. However the success rate is low if there are multiple stones and/or calcified stones and the stone size exceeds 20 mm. If the diameter of biliary stone is more than 20 mm than the risk of basket impaction

as well as fracture of the basket at the junction between the distal and proximal parts may occur^[8]. Once the basket catch the stone, there should be enough space between the stone and biliary channel wall to release the stone from basket in case of failed crushing. By definition basket impaction is expressed as inability to withdraw the basket with stone from papillary orifice or separate the stone from the basket in biliary channel lumen. Since there are only sporadic case reports, the precise treatment is still controversial. At present endoscopic or surgical procedures can be recommended after basket impaction. Endoscopic procedures should be tried if there is adequate experience and specialized endoscopic devices. In such a case extension of the sphincterotomy should be attempted first since the most likely cause of impaction is inadequate sphincterotomy and tissue edema. It can be applied when it is clear that the sphincterotomy can be safely extended. The special equipment required is a duodenoscope with a 4.2 mm working channel^[16]. However this can lead to duodenal perforation in inexperienced hands. Percutaneous transhepatic route can also be used in suitable cases by using a goose-neck snare in skilled radiology department^[3]. Dilating the papillary orifice is sometimes useful to remove the impacted stone-basket complex with the larger balloon^[17,18]. These endoscopic procedures are sophisticated and not widely available everywhere. Basket impaction represents a surgical emergency unless other non operative maneuvers like extracorporeal shock wave, intracorporeal electrohydraulic lithotripsy or catching the basket tip with a second basket are available^[9-11,19]. Additionally since our patients required additional surgical procedures for cholelithiasis, open surgery was preferred to treat the current basket impaction problem. In our series all patients also had cholelithiasis thus required cholecystectomy. The basket stone complex was removed through a longitudinal choledochotomy incision. It was repaired with primary closure in four patients and T-tube placement in two patients. In our centre we routinely close choledochotomy incision primarily in patients with previous sphincterotomy. But two patients in the present report were treated with T-tube placement since there are severe inflammation, cholangitis and transmural thickening at the biliary channel. The frequency of diverticula at our 2092 ERCP procedures is approximately 25%, but in the present report we found that 4 patients in 6 basket impaction had duodenal diverticula. This high ratio considered us that the occurrence of periampullary diverticula might be a predisposing factor for basket impaction. Small number of patients is our limitation so that the results can not be extrapolated to surgery clinics. However to our knowledge it is the largest series dealing with the open surgery in such patients. So it can suggest an

alternative surgical approach besides endoscopic interventions in otherwise healthy patients without comorbidity. In conclusion impaction or wire fracture of basket is an uncommon complication during ERCP and stone extraction. There are several treatment protocols and it should be tailored to the patient's clinical condition, endoscopist's experience and ERCP unit equipment.

COMMENTS

Background

Endoscopic retrograde cholangiopancreatography (ERCP) is mainly indicated for choledocholithiasis. Endoscopic basket impaction is a rare and unusual complication that can be seen after an attempt for removal of biliary stones with basket during ERCP. It is defined as inability to withdraw the basket with stone from papillary orifice or separate the stone from the basket in biliary channel lumen. Endoscopic or surgical procedures can be applied for the basket impaction. Non operative endoscopic maneuvers like extracorporeal shock wave, intracorporeal electrohydraulic lithotripsy, catching the basket tip with a second basket, balloon dilatation of the sphincterotomy area or laser lithotripsy are preferable at high technology units. However open surgical procedures can also be applied in selected cases.

Research frontiers

In the present study, the authors reported the results of six patients with endoscopic basket impaction that have been treated with open surgery.

Innovations and breakthroughs

In literature non-operative endoscopic procedures are widely recommended for ERCP-related basket impactions. These procedures require experienced endoscopists and sophisticated technological equipment. However these techniques and endoscopic devices are not widely available in every endoscopy centre. Therefore open surgery is still an alternative approach for such patients.

Applications

Open surgery by performing choledochotomy can be applied for the patients with basket impaction during ERCP procedure as an alternative to endoscopic interventions in selected cases.

Terminology

ERCP is abbreviation of endoscopic retrograde cholangiopancreatography and is an endoscopic technique to view the biliary and pancreatic channels. It is also used to remove the stones from these channels. Basket impaction is defined as inability to withdraw the basket with stone from papillary orifice or separate the stone from the basket in biliary channel lumen. It can be treated with open surgery including choledochotomy (incizing the choledochus and removing the stone and basket together) and closing the choledochus by primary closure or T-tube placement.

Peer-review

This paper reported the results of six patients with endoscopic basket impaction that have been treated with open surgery. The results are interesting and encouraging, which provided the practical basis that open surgical procedures could be selected when endoscopic basket impaction occurred.

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Hepatic portal venous gas after endoscopy in a patient with anastomotic obstruction

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colonoscopy performed through the stoma showed complete anastomotic obstruction. The mucosa of the proximal sigmoid colon was atrophic and whitish. Ten days after the colonoscopy, the patient presented in shock with abdominal pain. Abdominal computed tomography scan showed hepatic portal venous gas (HPVG) and a dilated left colon. HPVG induced by obstructive colitis was diagnosed and a transverse colostomy performed emergently. His subsequent hospital course was unremarkable. Rectal anastomosis with diverting ileostomy is often performed in patients with low rectal cancers. In patients with anastomotic obstruction or severe stenosis, colonoscopy through diverting stoma should be avoided. Emergent operation to decompress the obstructed proximal colon is necessary in patients with a blind intestinal loop accompanied by HPVG.

Key words: Portal venous gas; Abdominal computed tomography; Colonoscopy; Anastomotic obstruction; Bacterial translocation

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Core tip: A rare case of hepatic portal venous gas (HPVG) is reported. Endoscopy through ileostomy led the formation of HPVG induced by obstructive colitis. The anastomosis of rectum was totally obstructed after rectum cancer operation. For nine months, the mucosa of ascending to sigmoid colon has changed atrophy for disuse. The patient's condition improved after emergent operation of transverse colostomy. In patients with anastomotic obstruction or severe stenosis, colonoscopy through diverting stoma should be avoided.

Abstract

A 72-year-old male underwent a laparoscopic low anterior resection for advanced rectal cancer. A diverting loop ileostomy was constructed due to an anastomotic leak five days postoperatively. Nine months later,

Sadatomo A, Koinuma K, Kanamaru R, Miyakura Y, Horie H, Lefor AT, Yasuda Y. Hepatic portal venous gas after endoscopy in a patient with anastomotic obstruction. *World J Gastrointest Surg* 2015; 7(2): 21-24 Available from: URL: <http://www.wjgnet.com>

INTRODUCTION

Hepatic portal venous gas (HPVG) is a rare radiological sign associated with a wide range of abdominal abnormalities, ranging from benign to life-threatening conditions. Factors leading to gas in the portal vein include mucosal damage caused by necrosis, bowel obstruction, and sepsis^[1]. We report a case of HPVG following endoscopy performed through an ileostomy. The patient had severe anastomotic stenosis after low rectal cancer resection leading to a functional blind loop.

CASE REPORT

The patient is a 72-year-old man who underwent laparoscopic low anterior resection of rectal cancer nine months prior to presentation. Five days after the rectal resection with primary anastomosis, he underwent construction of a diverting ileostomy because of an anastomotic leak. The remainder of the hospital course was uneventful after the second operation. Histopathology showed a moderately-differentiated adenocarcinoma with metastases to regional lymph nodes (T3N1M0). Adjuvant chemotherapy including tegafur-uracil (UFT) and leucovorin (UZEL) was administered for 6 mo.

Colonoscopy performed per anus, eight months after resection, revealed severe stenosis at the rectal anastomosis. The pinhole lumen was covered by hard granulation tissue, and the endoscope could not pass through the hole. Following this, colonoscopy was performed through the ileostomy to examine the proximal colon, which confirmed that the anastomosis was completely obstructed and the proximal sigmoid colon mucosa was atrophic and whitish, consistent with chronic ischemic mucosal damage (Figure 1). The procedure was performed in 63 min. The patient complained of mild abdominal pain during the colonoscopy, but the pain improved soon after the examination. Six days after the colonoscopy, he visited his local physician with complaints of appetite loss and slight fever. He was diagnosed with acute enteritis based on laboratory data consistent with inflammation, and treated with oral antibiotics and an intestinal remedy.

Ten days after the colonoscopy, he visited our hospital with a temperature of 40 °C, blood pressure of 83/49 mmHg, and pulse of 100/min. Physical examination showed mild tenderness in the lower part of the abdomen with no sign of peritonitis. Laboratory data showed a white blood cell count of 8900/mm³, C-reactive protein of 18.1 mg/dL, metabolic acidosis (PH = 7.374, anion gap of 12),

and lactate dehydrogenase level of 1.1 mmol/L. Abdominal computed tomography (CT) scan showed a large amount of HPVG. The transverse, descending and sigmoid colon were dilated with no free air or ascites (Figure 2).

We believe that HPVG was caused by obstructive colitis and septic shock following colonoscopy. An emergency laparotomy was performed, which revealed that the transverse colon was edematous and purple violet (Figure 3). A transverse colostomy was constructed. Stool culture revealed presence of *Pseudomonas aeruginosa*. The postoperative course was uneventful and he was discharged on the seventh postoperative day. Four months later, ileostomy closure was performed.

DISCUSSION

HPVG was first described by Wolfe and Evens in infants^[2] and has been associated with serious underlying diseases and a high mortality rate. HPVG has been reported to be associated with many conditions, such as necrotizing enterocolitis, bowel ischemia, Crohn's disease, ulcerative colitis, graft-vs-host disease, bowel obstruction and iatrogenic complications^[3]. HPVG has been associated with procedures including endoscopy^[4,5], laparoscopy, endoscopic retrograde cholangiopancreatography^[6], esophageal variceal band ligation and percutaneous endoscopic gastrostomy tube placement^[7].

The diagnosis of HPVG is often made by abdominal CT scans with high sensitivity. It is possible to detect even a small amount of HPVG, leading to the early diagnosis of HPVG. HPVG is not necessarily an indication for surgery, and the prognosis depends on the underlying disease. Allaparthi *et al*^[7] reported that the mortality rate of HPVG was 25% to 35%. HPVG associated with bowel necrosis and ischemia usually has a high risk of mortality, so urgent laparotomy is recommended for such patients. Patients with a more equivocal clinical presentation might be treated non-operatively with intensive monitoring^[8]. In the present patient, clinical findings indicated that the patient was in septic shock and emergent operation was needed.

Factors that predispose to the development of HPVG include: (1) mucosal damage; (2) bowel distention; and (3) sepsis^[1]. Two or three of these conditions often coexist in many patients. Mucosal damage may be secondary to necrotic bowel, ulcerative colitis, or ulcer disease. Intraluminal gas can enter the capillary veins easily through a damaged mucosal barrier. Intraluminal pressures are increased by enema or colonoscopy. An intra-abdominal abscess can contain gas-forming organisms leading to HPVG. In this patient, anastomotic leakage and subsequent stenosis was likely caused by impaired blood flow to the left colon. The colonic mucosa became atrophic because of the absence of

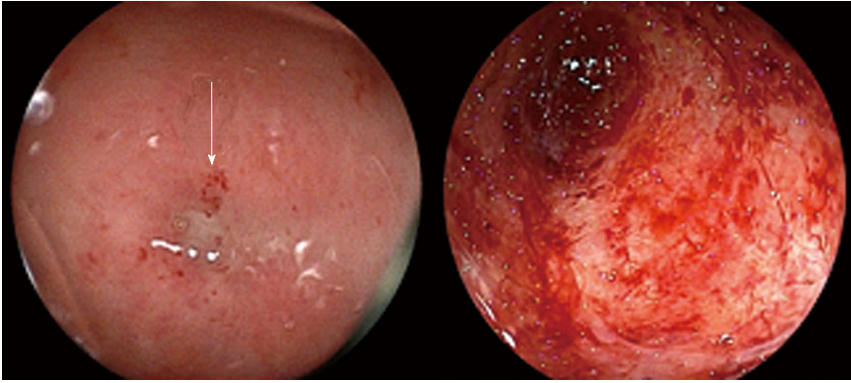


Figure 1 Colonoscopy through the ileostomy showed a tight stricture of the sigmoid colon at the anastomotic site (arrow). The mucosa of the sigmoid colon was severely atrophic (right panel).

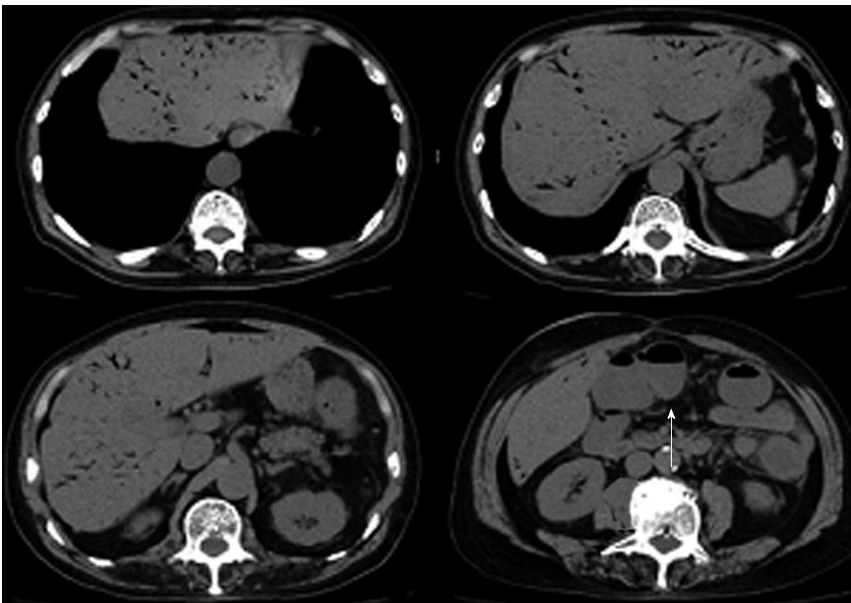


Figure 2 Computed tomography scan of the abdomen showed a marked amount of air throughout the portal venous system. The transverse colon was dilated (arrow).



Figure 3 Intraoperative findings. The transverse colon was edematous.

fecal passage for over 9 mo. A closed loop from the ileocecal valve to the site of the anastomotic stricture became a functional blind loop and intraluminal pressures were increased by the colonoscopy.

Although no bacterial blood cultures were obtained, we suggest that HPVG and sepsis were caused by bacterial translocation.

A rectal anastomosis with diverting ileostomy is performed in many patients with distal rectal cancer. In the case of anastomotic obstruction or severe stenosis, the colon proximal to the anastomosis may become a closed loop. Colonoscopy through the ileostomy should be avoided. Emergent surgery to decompress the obstructed bowel is necessary in such patients with a blind loop accompanied by HPVG.

COMMENTS

Case characteristics

Seventy-two years old man presented in shock with abdominal pain and high fevers ten days after colonoscopy through ileostomy.

Clinical diagnosis

Physical examination showed mild tenderness in the lower part of the abdomen

with no sign of peritonitis.

Differential diagnosis

Sepsis, gastrointestinal perforation.

Laboratory diagnosis

White blood cells: 8900/mm³; C-reactive protein: 18.1 mg/dL; metabolic acidosis (PH 7.374, anion gap of 12).

Imaging diagnosis

Abdominal computerized tomography scan showed a large amount of hepatic portal venous gas (HPVG) and dilated transverse, descending and sigmoid colon.

Treatment

Emergent operation of transverse colostomy was done.

Related reports

Some cases of iatrogenic HPVG were reported in English literature and they are named in author's references. This is the first case report of HPVG induced by colonoscopy through ileostomy.

Experiences and lessons

In the case of anastomotic obstruction or severe stenosis, colonoscopy through ileostomy should be avoided.

Peer-review

It is interesting.

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