Small bowel obstruction after a capsule enteroscopy

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DESCRIPTION

A 74-year-old woman with a history of Crohn's disease, presented with colicky abdominal pain, absolute constipation and vomiting a week after capsular enteroscopy, performed as part of investigation of faecal occult blood positive anaemia. Her physiological parameters were within normal limits, abdomen was distended, but non-tender, and there were no clinically apparent hernias. She had no history of gastrointestinal surgery or other significant medical history. Abdominal x-ray revealed the classical radiological features of small bowel obstruction proximal to the capsule (figure 1).

Wireless capsular enteroscopy is being increasingly used to investigate the small bowel, particularly in cases of obscure gastrointestinal bleeding, defined as bleeding from the gastrointestinal (GI) tract, which persists or recurs without an obvious cause identified upon upper GI endoscopy, colonoscopy or radiological examination of the small bowel.¹ The capsule is small enough to be swallowed (approximately 11×27 mm), although about 10% report difficulty with this. There is a risk of capsule retention of about 1.9% (retention of capsule >2 weeks) or obstruction; this may resolve spontaneously, as in this case, or require intervention. Rates of retention and obstruction may be higher in certain patient groups, such as those with Crohn's disease, owing to the presence of strictures²; Crohn's stricture was a contributing factor in this case.

In the first instance, contact should be made with the local capsule enteroscopy service for further advice. Double balloon enteroscopic capsule retrieval may be possible in simple capsule retention, thereby negating the need for any surgical intervention.

Figure 1 The capsule is seen in the right iliac fossa of this plain abdominal x-ray, with the proximal small bowel demonstrating the classical features of obstruction (dilated loops of centrally located bowel with visible valvulae conniventes).

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Sidhu R, Sanders D, Morris AJ, et al. Guidelines on small bowel enteroscopy and capsule endoscopy in adults. *Gut* 2008;57:125–36.
- 2 Szold A, Katz LB, Lewis BS. Surgical approach to occult gastro-intestinal bleeding. *Gastroenterology* 2005;128:1424–30.

Learning points

- ▶ The use of wireless capsule enteroscopy has increased significantly in recent years, becoming the 3rd-line investigation for obscure gastrointestinal (GI) bleeding after upper GI endoscopy and colonoscopy.¹
- ▶ Capsule retention occurs in 1–2% of patients, though may be higher in certain groups (e.g. Crohn's disease).
- ▶ Obstruction and capsule retention may resolve spontaneously or require intervention (surgical or endoscopy); advice should be sought from the local capsule enteroscopic service.

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