Colonic Intramural Hematoma After Argon Plasma Coagulation

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Argon plasma coagulation (APC) is a noncontact endoscopic method of hemostasis achieving coagulation without physical contact of APC probe with tissues. APC was first developed for surgical interventions but has been introduced to endoscopic procedures since 1991. It is currently used for the management of bleeding caused by varices, ulcers and vascular ectasias as well as for ablation of Barret’s esophagus, remnant adenomatous tissues after polypectomy and debulking malignant tumors. It is the most preferred method to manage angiodysplasia owing to its ease of application, minimum depth of thermal effects and speedy treatment for wide areas. It is known to be an effective method of hemostasis to treat colonic angiodysplasia and complication rates are also low when it is performed after submucosal injection of saline. The main advantage of APC is the safety owing to minimum depth of the thermal effect but procedure-related complications such as pneumoperitoneum, perforation, subcutaneous emphysema, bleeding, stricture and pain can occur if it is inappropriately used. However, incidence of intramural hematoma is rare. There is only one reported case of intramural hematoma which developed in the stomach after argon plasma coagulation to remove residual tissues after gastric polypectomy. Herein, we report a case of colon intramural hematoma and delayed bleeding after argon plasma coagulation performed to manage bleeding secondary to colonic angiodysplasia in a 57-year old female with liver cirrhosis and end stage renal disease.

Treating Peutz-Jeghers syndrome surgically with combined intraoperative enteroscopy: Case report

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The Peutz-Jeghers syndrome is an autosomal dominant inherited disease manifested by a combination of mucocutaneous pigmentation and gastrointestinal hamartomatous polyps that usually cause intussusception and intestinal hemorrhage. We report a case of a 40-year-old man with Peutz-Jeghers syndrome, who was diagnosed 20 years ago and operated on several times for intestinal occlusion due to intestinal intussusception. The patient was admitted to our clinic with hematochezia due to the multiple colon polyps. With the use of combined surgery and perioperative endoscopy, total 76 polyps were removed, performing 5 enterotomies. To date our patient is free of any overt intestinal occlusion symptoms or other symptoms due to PJS. In conclusion, prophylaxis and polypectomy of the entire small bowel is the gold standard in PJS patients. The usefulness of this technique is providing a "clean small intestine" that allows the patient a longer time interval between laparotomies and reduces the complications associated with multiple laparotomies and resections.