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Diagnostic and therapeutic utility of double-balloon enteroscopy for obscure GI bleeding in patients with surgically altered upper GI anatomy

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Obscure GI bleeding (OGIB) poses a unique challenge in patients with surgically altered GI anatomy. In patients with normal anatomy, approximately only 5% of cases of GI bleeding occur between the ligaments of Treitz and the ileocecal valve; however, double-balloon enteroscopy (DBE) has given us increased access to the small bowel and has revealed a variety of small-bowel bleeding etiologies including arteriovenous malformation, jejunal varices, ulcerations, and small-bowel tumors, among others, as common sources of OGIB.¹⁻³ Alterations to GI anatomy further obscure management by providing the anastomotic site as a potential site of bleeding and by making the excluded stomach inaccessible to both conventional endoscopy and video capsule endoscopy.^{4,5} The American Society for Gastrointestinal Endoscopy currently recommends that in patients with surgically altered anatomy, deep enteroscopy may be considered as the initial small-bowel diagnostic procedure in patients with OGIB.⁶ Despite this recommendation, there is a paucity of data describing the diagnostic and therapeutic management of OGIB in patients with surgically altered anatomy.⁷ To our knowledge, no study has specifically evaluated the utility

of DBE for OGIB in patients with Roux-en-Y anatomy. The aim of this study was to evaluate the potential use and feasibility of DBE in patients with complex postoperative upper GI anatomy and OGIB such as Roux-en-Y.

PATIENTS AND METHODS

Consecutive patients with altered GI anatomy and OGIB who underwent DBE between October 2012 and November 2013 at the University of Alabama at Birmingham were included and their data recorded in a retrospectively collected database. The study was approved by the institutional review board. All patients provided written, informed consent to undergo DBE, including endoscopic therapy (hemoclip, over-the-scope clip, epinephrine-saline solution [1:10,000], argon plasma coagulation [APC]). Data abstracted for analysis included patient demographic characteristics, medical history, indication for endoscopy, endoscopic findings, endoscopic procedures, and adverse events. Vascular lesions (arteriovenous malformations and Dieulafoy's lesions) were defined according to the classification proposed by Yano et al.⁸ Dieulafoy's lesions are characterized by being strictly arterial, and angiodysplasia is characterized as a venous and capillary lesion.⁸ Neovascularization was defined as the de novo formation of blood vessels in tissue.⁹

Procedure description

The patients were placed in the decubitus supine position. All procedures were performed with patients under general anesthesia. The EN450-T5 enteroscope (Fujinon Inc, Wayne, NJ) was used for all DBEs. The enteroscope includes a 230-cm-long endoscope, an overtube, and a double-barostatic pump (PB-10 balloon pump controller) that allows controlled inflation of the endoscope and overtube balloons. All DBEs were performed in a standard endoscopy unit with a fixed fluoroscopy unit. Patients were

Abbreviations: APC, argon plasma coagulation; DBE, double-balloon enteroscopy; GIB, GI bleeding; OGIB, obscure GI bleeding.

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TABLE 1. Case characteristics

Patient	Case	Sex	Age, y	GIB indication	Anatomy	Findings	Stomach	Therapy	Adverse events
1	1	F	58	Occult	Gastric bypass Roux-en-Y	None	Normal	None	None
2	1	M	69	Overt	Pylorus-sparing Whipple	Downhill esophageal varices, hiatal hernia, hepaticojejunostomy anastomosis neovascularization	Normal	APC	None
	2	M	70	Overt	Pylorus-sparing Whipple	Downhill esophageal varices, hiatal hernia hepaticojejunostomy anastomosis neovascularization	Normal	APC	None
	3	M	70	Overt	Pylorus-sparing Whipple	Downhill esophageal varices, hiatal hernia, hepaticojejunostomy anastomosis neovascularization	Normal	None	None
3	1	F	55	Overt	Gastric bypass Roux-en-Y	Jejunojunal anastomosis neovascularization	Normal	APC, clip, epinephrine solution injection	EBL: 150 mL
	2	F	55	Overt	Gastric bypass Roux-en-Y	Jejunojunal anastomosis neovascularization	Normal	APC, with recommendation for surgical revision	None
4	1	F	36	Overt	Gastric bypass Roux-en-Y	Jejunojunal anastomosis neovascularization	Normal	APC	Perforation of jejunojunal anastomosis requiring emergent operative repair
5	1	M	62	Overt	Pylorus-sparing Whipple	Hepaticojejunostomy anastomosis neovascularization and erosion with pulsating vessel at base	Normal	APC, clips	None
	2	M	62	Overt	Pylorus-sparing Whipple	Hepaticojejunostomy anastomosis neovascularization	Normal	APC, with particular attention to avoid prior clips or staples	None
6	1	F	54	Occult	Gastric bypass Roux-en-Y	Superficial ulcer with inflammatory polyp	Normal	None	None
	2	F	55	Occult	Gastric bypass Roux-en-Y	Healed ulcers at jejunojunal anastomosis, bleeding nodule on anastomosis	Normal	2 clips	None
7	1	M	56	Overt	Gastrojejunostomy Roux-en-Y	Jejunojunal anastomotic neovascularization	Normal	2 clips	None

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