

fact that feeding into the stomach by PEG tube and dislocation or clogging of a PEG-J tube into the stomach led to exacerbation of symptoms in all cases. PEG-J tubes can bypass the stomach and deliver nutrition effectively into the jejunum. PEG-J tube placement also leads to decreased gastric residual volume, which can decrease vomiting frequency. So far, there have been 3 previous reports (n = 5) of hyperemesis gravidarum managed with PEG-J tubes.¹⁰⁻¹² However, HEG was not classified as severe versus not severe, and details of the procedures involving PEG-J tube placement in pregnant patients were not described in these reports.

In conclusion, endoscopically inserted feeding tubes at an experienced facility may be a safer method of providing enteral nutrition in patients with severe HEG to prevent adverse maternal and fetal outcomes.

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Ileoscopic balloon dilation of Crohn's disease strictures via stoma

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Permanent ileostomy with or without a partial or complete colectomy is a surgical modality in treating patients with severe distal or perianal Crohn's disease (CD). Approximately 10% of patients with CD will eventually have a permanent stoma.¹ Adverse events after stoma surgery are common, such as retraction, prolapse, and peristomal pyo-

Abbreviations: CD, Crohn's disease; IBD, inflammatory bowel disease; IC, indeterminate colitis; IQR, interquartile range; IRB, Institutional Review Board; NSAID, non-steroidal anti-inflammatory drugs; SD, standard deviation; TNF- α , tumor necrosis factor- α ; UC, ulcerative colitis.

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derma gangrenosum. One of the most significant adverse sequelae in CD patients with stomas is the development of strictures at the distal small bowel. In addition to recurrent CD, other factors may contribute to the development of strictures, including nonsteroidal anti-inflammatory drug (NSAID) use, surgery-related ischemia, or the healing process after medical therapy for bowel inflammation, particularly after anti-tumor necrosis factor- α (anti-TNF- α) therapy.²

The management of CD strictures, especially fibrostenotic ones, can be challenging, because their mechanical nature often makes them refractory to medical therapy. Therefore, those fibrostenotic strictures usually have been managed with surgical intervention, including bowel resection or stricturoplasty. However, patients treated with the surgery carry the risk of developing operative morbidity and mortality. In addition, strictures often recur after surgery, with a reported frequency ranging from 19% to 34%.^{3,4}

For the past decade, endoscopic therapy has emerged as a valid alternative to surgical treatment. The endoscopic approach is less invasive than surgery. Endoscopic

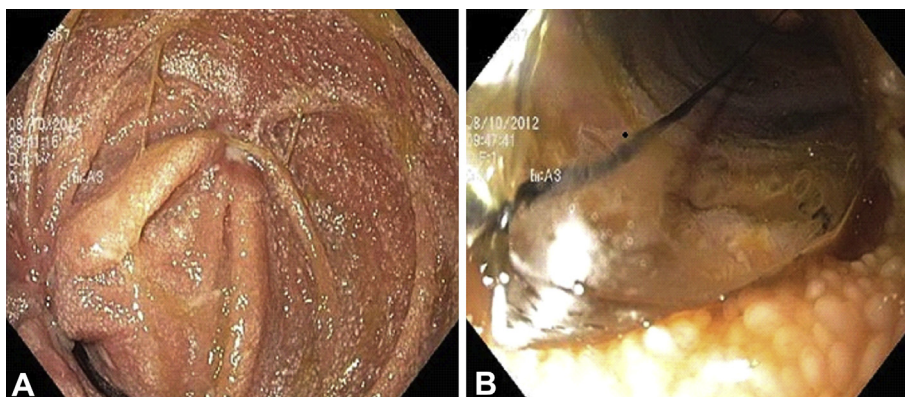


Figure 1. Ileoscopy balloon dilation via stoma in a patient with a small-bowel Crohn's disease stricture. **A**, Direct visualization of the neo-distal small-bowel CD stricture. **B**, Inflation of ileoscopic balloon.

balloon dilation has been shown to be an effective and safe option for the treatment of strictures at the colon,⁵⁻⁷ small bowel,^{8,9} and ileal pouch¹⁰ in CD patients without ileostomy. However, there were no published studies in the current literature in the management of small-bowel strictures in patients with ileostomies. The aim of this study was to assess the feasibility, efficacy, and safety of ileoscopic balloon dilation of small-bowel strictures in patients with CD with permanent end ileostomies.

METHODS

Patients

The Cleveland Clinic Institutional Review Board approved this study (IRB #13-660). Consecutive patients were identified from our Center for Inflammatory Bowel Disease (IBD) from January 2001 to July 2013.

Inclusion criteria were: (1) CD patients with permanent end ileostomies; (2) patients having small-bowel strictures, with or without bowel obstruction symptoms; and (3) ileoscopic balloon dilation of strictures via a stoma. Excluded were those with (1) underlying ulcerative colitis (UC) or indeterminate colitis (IC) with temporary loop ileostomy for the ileal pouch construction; (2) conditions other than inflammatory bowel disease, such as motor vehicle accident; (3) temporary diverting ileostomy; (4) small-bowel strictures longer than 5 cm, which were not amenable to endoscopic dilation; (5) strictures complicated by fistula or abscess; (6) malignant strictures; or (7) ileal pouch strictures.

Endoscopic protocol

Informed consent pertaining to endoscopic treatment of strictures was obtained from all patients undergoing ileoscopy via stoma. Routine diagnostic or surveillance (for monitoring of recurrent CD) ileoscopy was performed in an outpatient setting by the experienced endoscopist (B.S.). Before the initial procedure, patients typically had

CT enterography and/or retrograde water-soluble contrasted enema via the stoma to delineate the number, degree, length, and location of strictures and associated conditions (such as fistula or abscess). Once strictures were detected during endoscopy, balloon dilation therapy was routinely performed, regardless of the presence or absence of symptoms.

The postoperative endoscopic recurrence of CD in patients with ileostomies was retrospectively graded, based on the Rutgeerts Score.¹¹ The degree of strictures was quantified by the endoscopist, based on the degree of resistance to the passage of an upper endoscope¹⁰ (0 = no resistance; 1 = mild resistance; 2 = moderate resistance; 3 = severe resistance; and 4 = pinhole and not traversable).

Ileoscopy dilation not guided by fluoroscopy was performed via stoma with an 8.6-mm, flexible, single-channel, upper endoscope (GIF-160 or H-180 series; Olympus Optical, Tokyo, Japan), with a through-the-scope balloon system (CRE balloon, Boston Scientific Microvasive, Natick, Mass). The balloon size ranged from 16 to 20 mm. For high-grade or angulated strictures not traversable to the endoscope, antegrade, wire-exchange technique balloon dilation was used (Fig. 1).

Intralesional corticosteroid injection was performed in selected patients at the discretion of the endoscopist. A long-acting, non-diluted corticosteroid (Kenalog 50 mg/5 mL) was injected. In selected patients with tight, fibrotic strictures that were refractory to endoscopic balloon dilation, endoscopic needle-knife stricturotomy was attempted.

Patients were closely monitored for signs of excessive bleeding and bowel perforation after the procedure in the endoscopy recovery room for at least 30 minutes.

Definitions of variables

Demographic and clinical variables were defined as follows: (1) active smoker—consumption of more than 7 cigarettes per week for at least 6 months before the

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