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Ileal-J-Pouch Volvulus After Restorative Proctocolectomy

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1 **Ileal-J-pouch volvulus after restorative proctocolectomy**

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25 investigated and resolved.

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28 the work in ensuring that questions related to the accuracy or integrity of any part of the work are
29 appropriately investigated and resolved.

30

31 **Case Presentation**

32 A 45-year-old woman presented with bowel obstruction. She underwent a restorative
33 proctocolectomy with ileal-J-pouch-anal anastomosis (IPAA) 3 years previously for „ulcerative colitis-like“
34 Crohn’s disease resistant to medical treatment. On physical examination, she had lower abdominal
35 tenderness and acute intestinal obstruction. Abdominal computed tomography scan revealed small bowel
36 obstruction above a volvulus of the ileal-J-pouch (fig. 1 A and B). Axial maximum intensity projection
37 showed whirling of staple lines of the pouch (fig 1 C). Endoscopy confirmed a complete whirling of the
38 pouch but endoscopic detorsion failed and was complicated with pouch perforation. Surgical exploration
39 showed pouch ischemia without necrosis. Manual detorsion of the pouch, suture of the perforation and
40 pexy of the pouch were done. Suture was protected with an omental flap and a diverting stoma.
41 Opacification of the pouch and pouch endoscopy two months later showed normal aspect of the pouch.
42 Outcomes of the closure of stoma were uneventful.

43 **Discussion**

44 Ileal pouch volvulus is a rare complication, only 22 cases reported in a recent review, usually
45 diagnosed by computed tomography [1]. The delay of occurrence was late with a median time to volvulus
46 after IPAA of 36 months as in the present case. Secondary complications (i.e. ischemia, perforation)
47 occurred in 23% of cases and could lead to pouch excision [1]. Due to the small samples of patients,
48 highlighting risk factors for ileal pouch volvulus is not statistically possible. Absence of adherences
49 responsible of the mobility of the pouch is frequently described without abnormalities of pouch or
50 anastomosis technique. The majority of cases was published in the last 5 years. This fact possibly reflects
51 a large majority of laparoscopically performed IPAA resulting in less peritoneal adherences. The majority of
52 patients were female with larger and wider pelvis than men [1,2]. Some authors hypothesized that position
53 of the mesentery of the pouch could facilitate pouch volvulus. Recently, three cases described by Geers et
54 al. had IPAA constructed with mesentery positioned anteriorly [3]. Surgical management with pouch pexy
55 after endoscopic detorsion is the most frequent treatment. The case of a successful endoscopic detorsion
56 without surgical treatment is described in one patient free of relapse after 3-year follow-up [2]. Pouch pexy
57 consists in suturing both efferent and afferent limb of the pouch to the pelvic walls with interrupted
58 multifilament sutures [3]. This bilateral pouch pexy achieves a firm anchoring of the IPAA to avoid
59 recurrence.

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69 **Figure legend**

70 Figure 1: Abdominal computed tomography showed a whirl sign corresponding to the rotation of the ileal-J-
71 pouch around its axis (white arrows, A and B) confirmed by the rotation of staple lines in maximum intensity
72 projection (C).

