Endoscopic electrocautery incision therapy for benign lower gastrointestinal tract anastomotic strictures

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Abstract
Benign anastomotic strictures can occur in up to 22% of patients who undergo colonic or rectal resection [1]. Traditionally, surgery was the preferred method of treatment, but, over time, endoscopic techniques, such as balloon dilation, have become the preferred modality. However, a high stricture recurrence rate of up to 18-20% and the increased risk of perforation due to uncontrolled stretching are its major drawbacks. Endoscopic electrocautery incision (EECI) allows for controlled mucosal incision in predetermined locations of stricture. In this meta-analysis, we have summarized case reports, case series, retrospective studies and prospective studies describing the different endoscopic EECI techniques used for benign lower gastrointestinal tract anastomotic strictures. Our analysis showed that EECI, either alone or in combination with other modalities (e.g. balloon dilation, steroid injection or argon plasma coagulation) is an effective treatment option for both treatment-naïve and refractory short non-inflammatory strictures. The overall success rate for EECI-based therapy for benign colorectal stricture was 98.4%, with a stricture recurrence rate of 6.0%. No major adverse event (bleeding, infection or perforation) was reported. Only minor adverse events (abdominal pain) were reported in 3.8% of the population.

Keywords
Benign stricture, colorectal stricture, endoscopic incision therapy


Introduction
Benign anastomotic strictures can occur in up to 22% of patients who undergo colonic or rectal resection [1]. The incidence of postoperative colorectal strictures has risen over the years, partly as a result of an increase in the use of stapler devices for anastomotic closure [2]. The treatment of anastomotic strictures is imperative, to limit the risk of development of metachronous cancer lesions over time in patients with prior colorectal cancers and to avoid progression towards obstructive symptoms.

Traditionally, surgery was the preferred method of treatment of colorectal strictures. Over time, that has been replaced by endoscopic techniques, primarily balloon dilations and dilation with Savary-Gilliard bougies, which have been demonstrated as effective, simple, and safe [3]. However, in some cases the stricture can be inaccessible, or it can fail to improve with multiple sessions of dilatation. This technique also has a high stricture recurrence rate, up to 18-20%, and carries an increased risk of perforation as a result of uncontrolled stretching [3].

Endoscopic electrocautery incision (EECI) techniques have been described in the literature as alternative therapies for anastomotic strictures, or for resistant strictures that have failed treatment with dilatation. Electrocautery incision creates a defined mucosal incision at the most resistant location and leads to dilation of the stricture. These techniques have been reported to have a good success rate and a lower risk of adverse events, including perforation.

In this systematic review, we have summarized case reports, case series, retrospective studies and prospective studies describing the different EECI techniques used in colonic, rectal or colorectal benign anastomotic strictures.

Materials and methods
An extensive English language literature search was carried out of studies published until July 2016. PubMed and Google Scholar were used to identify the peer-reviewed original and review articles, based on the following key words: benign...
stricture, colorectal stricture, endoscopic incision therapy. Only human study subject articles were selected. The references of pertinent studies were searched manually to identify additional relevant studies. The search yielded case reports [4-6], case series [7-9], and prospective studies [10-13]. The stricture etiology, characteristics and location, device details, procedure details, success rate, complications and limitations were reviewed for each study.

Results

Ten original articles were considered appropriate to be included in this review article [4-13]. Three studies described the application of EECI: a case report from Germany [4], a case series from Korea [7] and a retrospective case series from Italy [9]. Three studies described an endoscopic electrocautery radial incision and cutting (RIC) technique: one case report from Brazil [5], a retrospective case series from Japan [8] and a prospective study from Italy [10]. A case report from USA described the use of adjunctive corticosteroids with EECI [6]. Two prospective studies described combination therapy with EECI and balloon dilation: one each from Japan [11] and Germany [12]. Another prospective study from Germany [13] described the role of combination therapy with EECI and Argon plasma coagulation (APC). All studies have been summarized in Table 1.

Discussion

Stricture

Etiology and location

Studies included in this review identified patients with post-surgical anastomotic stricture [4-13]. Post-surgical anastomotic stricture can occur as a result of tissue ischemia, inflammation, hemorrhage at the site of the suture line, anastomotic site leakage or recurrence of disease [17,18]. Anastomotic leakage has been shown to contribute towards increased inflammation, thereby contributing to an increased risk of fibrosis and stenosis. According to a Cochrane Database systematic review, a side-to-side stapled anastomosis has been recommended for ileocolic anastomosis, especially following a right hemicolectomy for colonic adenocarcinomas, because it results in fewer anastomotic leaks [20]. A recent meta-analysis for Crohn’s disease showed a higher rate of anastomotic leakage with end-to-end anastomosis compared to side-to-side [21].

The spectrum of surgical resections included those for malignant primary lesions, such as low anterior resection for rectosigmoid colon cancer and rectal cancer, intersphincteric resection for lower rectal cancer, hemicolecotomy or subtotal colectomy [5,7-13]. Patients undergoing proctocolectomy for familial adenomatous polyposis were also included by some studies in this review [4,6,9,10]. Stricture formation across all studies included occurred at the site of the surgical anastomosis [4-13].

Criteria, characteristics and timing

Anastomotic strictures following colonic and/or rectal resections can present with symptoms of abdominal pain, cramping, constipation or symptoms of bowel obstruction. Studies included in this review identified strictures after patients presented with symptoms or as a result of follow-up assessments. Various radiologic and/or endoscopic techniques were utilized to identify the stricture. Strictures of <10 mm diameter were commonly seen to have presented with obstructive symptoms. Strictures in the descending colon or rectum may often present clinically once luminal diameter is 20 mm or less.

The majority of the studies defined the stricture as the inability to pass an endoscope across the anastomosis site [6-13]. The size of the endoscope used varied across the studies, hence creating a wide variability in the stricture definition. Few studies used radiologic techniques, such as barium enema, barium swallow or CT scan, to define the stricture [7,10,11,13].

The diagnosis in these studies was followed by endoscopic confirmation of the stricture. Wallstabe et al [4] used digital palpation and pachyscopy to identify the area of fibrotic tissue, confirmed on biopsy. Truong et al, in a prospective study of 36 patients, defined three grades of stenosis according to the luminal diameter [12]. The severity of stenosis was closely related to the symptomatic presentation. Symptoms of bowel obstruction correlated with a luminal diameter of <5 mm, defined as grade-3 stenosis. The predominant use of stapled sutures in the index surgery was consistent across all three grades of stenosis. Anastomosis closure with a circular stapling device has been linked to an increase in the incidence of stricture to as high as 30% when compared with hand-sewn anastomosis [14-16]. This risk, however, is independent of the stapler diameter.

Benign stenosis of colonic, rectal or colorectal anastomosis can occur from as early as within the first postoperative month to as late as several years after the surgery [19]. Most subjects were diagnosed with a stricture in the first postoperative year [4,7-13]. One case reported by Dieuruf et al had a stricture diagnosed 12 years after the surgery [6].

Prior interventions

Only four studies reported the use of alternative techniques to treat the stricture before considering them for EECI therapy. The case reported by Wallstabe et al underwent six balloon dilations over 10 weeks after identification of the stricture [4]. Four months after the first dilation, a second series of treatment with balloon dilation, triamcinolone injections, as well as transanal advancement flap anoplasty, was carried out without success. Of the seven cases in the retrospective case
<table>
<thead>
<tr>
<th>Author/Year/ Location</th>
<th>Study Type</th>
<th>Number of subjects</th>
<th>Stricture etiology</th>
<th>Type of intervention</th>
<th>Outcome measure</th>
<th>Follow-up time</th>
<th>Success rate- % (absolute number)</th>
<th>Failure rate- % (absolute number)</th>
<th>Stricture recurrence</th>
<th>Complications (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wallstabe et al 2015 Germany [4]</td>
<td>Case report</td>
<td>1</td>
<td>Post-surgical-proctocolectomy with ileal-pouch anal anastomosis (IPAA) for ulcerative colitis complicated with anastomotic leak- 1/1</td>
<td>Endoscopic electrocautery incision</td>
<td>1. Symptom- Absence of evacuation impairment 2. Colonoscope: no restenosis (1 week, 6 weeks, 6 months and 1 year) 3. Digital palpation: Monthly</td>
<td>12 m</td>
<td>100 (1/1)</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Kawaguti et al. 2015 Brazil [5]</td>
<td>Case report</td>
<td>1</td>
<td>Post-surgical- resection of rectal adenocarcinoma with temporary ileostomy, followed by colorectal anastomosis- 1/1</td>
<td>Endoscopic electrocautery radial incision and cutting (RIC)</td>
<td>1. Colonoscope- no restenosis (1 m) 2. Symptoms- absent (8 m)</td>
<td>8 m</td>
<td>100 (1/1)</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Dieruf et al 2001 USA [6]</td>
<td>Case report</td>
<td>1</td>
<td>Post-surgical for sigmoid volvulus- 1/1</td>
<td>Endoscopic electrocautery incision with adjunctive corticosteroid injection</td>
<td>1. Immediate: Normal bowel movements 2. On follow up: a) Symptoms- absence of constipation and abdominal bloating b) Sigmoidoscope- wide patent anastomosis (5 m)</td>
<td>14 m</td>
<td>100 (1/1)</td>
<td>0</td>
<td>None</td>
<td>1. Postop leak: 0</td>
</tr>
<tr>
<td>Kwon et al 2014 Korea [7]</td>
<td>Case series</td>
<td>2</td>
<td>Post-surgical- low anterior resection (LAR) for recto-sigmoid colon cancer- 1/2</td>
<td>Endoscopic electrocautery incision</td>
<td>1. Colonoscope- no re-stenosis (12 m) 2. Symptoms- none</td>
<td>18 m</td>
<td>100 (2/2)</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

(Contd...)
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</tr>
</thead>
<tbody>
<tr>
<td>Bravi et al. 2015 Italy [9]</td>
<td>Case series</td>
<td>60</td>
<td>Post-surgical- colon or rectal cancer- 54/60 Post-surgical- sigmoid diverticulitis- 2/60 Post-surgical- anterior rectal resection for ovarian cancer- 2/60 Post-surgical- prophylactic proctocolectomy for familial adenomatous polyposis- 2/60</td>
<td>Endoscopic electrocautery incision</td>
<td>1. Immediate- Ability to pass standard colonoscope through anastomotic site after dilation 2. On follow-up: Absence of reappearance of stricture on surveillance colonoscopy (1 year post-op and then at 3 and 5 years)</td>
<td>1. Median- 35.5 m (Range: 2-144 m) 2. On long-term follow up- 95.0 (57/60)</td>
<td>0</td>
<td>3/60 (5%)- 2/3 - responded successfully to single session of electrocautery dilation- 1/3 - responded successfully to single session of Savary-Gilliard bougies dilation</td>
<td>1. Perforation- 0 2. Bleeding: 0</td>
<td></td>
</tr>
<tr>
<td>Brandimarte et al. 2000 Italy [10]</td>
<td>Prospective study</td>
<td>39</td>
<td>Post-surgical- resection of colon cancer- 30/39 Post-surgical- surgery for sigmoid diverticulitis- 9/39</td>
<td>Endoscopic electrocautery RIC</td>
<td>1. Immediate- Ability to pass endoscope through stenosis post incisions 2. Late-a) Symptoms - none b) Colonoscopy- every 3 m for 1st year, every 6 m for following year and then yearly</td>
<td>1. Mean: 25 m (Range: 8-43 m)</td>
<td>100 (39/39)</td>
<td>0</td>
<td>None</td>
<td>1. Bleeding: 0 2. Pain, abdominal or perineal: 0</td>
</tr>
<tr>
<td>Hagiwara et al 1999 Japan [11]</td>
<td>Prospective study</td>
<td>5</td>
<td>Post-surgical- anterior resection with diverting colostomy for rectal carcinoma- 2/5 Post-surgical- anterior resection without diverting colostomy for rectal carcinoma- 3/5</td>
<td>Endoscopic electrocautery incision and dilation</td>
<td>1. Barium enema- Improvement of more than one grade in stricture using formula by McAdams et al. 2. Symptoms- Alleviation of obstructive symptoms</td>
<td>Range: 9-15 m 1. 100 (2/2) (sensation of residual feces just after colostomy closure, with alleviation by 6 weeks) 1. 100 (3/3) (subjective symptoms improved every week with disappearance by 4 weeks)</td>
<td>0</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Truong et al 1997 Germany [12]</td>
<td>Prospective study</td>
<td>36</td>
<td>Post-surgical- right and left hemicolectomy, sigmoid resection, LAR of rectum- 36/36</td>
<td>Endoscopic electrocautery incision and consecutive hydraulic balloon dilatation</td>
<td>1. Symptoms- alleviation of obstructive symptoms 2. Imaging- abdominal ultrasound 2. Endoscopy- every 3 m for first year, then yearly</td>
<td>Mean- 45.1 m (Range: 12-81 m) 1. Early post intervention- a) Composite- 97.2 (35/36) i) Grade 1-100 (21/21) ii) Grade 2-100 (10/10) iii) Grade 3- 80 (4/5) 2. On long-term follow up- 85.7 (30/35) 2.6 (1/36) (one failure was due to inability to perform complete electro-incision secondary to lack of complete epithelialization) 2.6 (1/36) (one failure was due to inability to perform complete electro-incision secondary to lack of complete epithelialization)</td>
<td>Composite- 5/35 (14.3%) 2. Grade 2-2/10 (successful response to BD) 3. Grade 3- 3/4 (successful response to BD)</td>
<td>1. Perforation- 0 2. Bleeding: 0 3. Local pain- 1 4. Anastomotic ulcers: 1 (subject had grade 3 stenosis)</td>
<td>(Contd...)</td>
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</tbody>
</table>
Endoscopic incision therapy for benign colorectal stricture

Schubert et al. [13] performed endoscopic electrocautery incision followed by reduction of scar tissue with Argon plasma coagulation (APC) in 15 patients who had undergone post-surgical gastrectomy and esophagojejunostomy, esophagectomy and mediastinal esophagogastrostomy, or esophagectomy and colon interposition [5].

### Outcome measure

1. **Success rate (%)**
   - Early post-intervention: 100 (15/15)
   - On long-term follow-up: 93.3 (14/15)

2. **Failure rate (%)**
   - 0.3 (1/34)

3. **Complications**: 6.6% (3/46)
   - Perforation: 0
   - Bleeding: 0

### Procedure details

#### Anesthesia and bowel preparation

Only four studies reported the type of anesthesia used for the procedure. Osera et al. [8] used conscious sedation with 2-3 mg of IV midazolam and analgesia with 35 mg of IV pethidine. Bravi et al. [9] used 5-10 mg of IV diazepam or 2.5-5 mg of IV midazolam for conscious sedation in 53 of the 60 patients included. The remainder (7/60) opted out of receiving any conscious sedation for the procedure. No patient discomfort or pain was reported by either group of patients [9].

Two prospective studies by Truong et al. [12] and Schubert et al. [13] also utilized conscious sedation and/or analgesia. The former used 5-10 mg of IV diazepam with 40 mg of IV butyl-scopolamine and the latter used 4-10 mg of IV midazolam [12,13]. No complications as a result of conscious sedation were reported in the studies detailed above.

With regard to bowel preparation, investigators used a regimen of liquid diet, oral laxatives and cleansing enemas to achieve a quality of bowel preparation that would allow adequate visualization for the therapy [9,10,12,13].

#### Technical details

All studies included in the review utilized the EECI technique, either alone or in combination with another modality. Three studies described the isolated use of EECI technique for stricture [4,7,9]. Wallstabe et al. incised the stricture at 3 points using an ERCP sphincterotome and a precut knife [4]. Case reports by Kwon et al. described incisions based on the stricture length and caliber determined either endoscopically or radiologically [7]. The length and depth of the incision were gauged by the endoscopist and never crossed the muscular layer. The electrocautery therapy lasted for about 5-10 min. An insulated tip (IT) knife and a bimodal electrocautery were used along with a 12 mm colonoscope [7].

A similar approach was used in the case series by Bravi et al., series by Osera et al., five underwent bougie dilation and the rest underwent balloon dilation at least more than twice before they were termed as refractory [8]. In the case reported by Dieruf et al., balloon dilation was performed to a maximum diameter of 18 mm, but was followed by recurrence of abdominal distention after 48 h [6]. Hagiwara et al. attempted two to three sessions of balloon dilations on all 41 patients, 12% (5/41) of whom failed to improve [11]. Balloon dilation of stenotic segments of the gastrointestinal tract has proved to be a convenient and less invasive treatment method. However, the majority of the patients require multiple sessions for the resolution of symptoms and recurrence is observed in about 18% of patients [3,22].

All details regarding stricture etiology, location, criteria, characteristics, time interval to develop and interventions performed prior to consideration for EECI therapy have been summarized in Table 2.

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A similar approach was used in the case series by Bravi et al.,...
### Table 2: Stricture characteristics for each study

<table>
<thead>
<tr>
<th>Author/Year/Location</th>
<th>Number of subject</th>
<th>Stricture etiology</th>
<th>Details of anastomotic closure</th>
<th>Time interval for stricture to be diagnosed from index surgery</th>
<th>Stricture definition and characteristics</th>
<th>Stricture location</th>
<th>Previous interventions done to treat the stricture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wallstabe <em>et al</em> 2015 Germany [4]</td>
<td>1</td>
<td>Post-surgical- proctocolecotomy with ileal- pouch anal anastomosis (IPAA) for ulcerative colitis complicated with anastomotic leak- 1/1</td>
<td>DNA</td>
<td>10 weeks (wks)</td>
<td>1. Digital palpation and pouchoscopy 2. Fibrotic tissue without de novo inflammatory bowel disease (IBD) on biopsy</td>
<td>IPAA site</td>
<td>6 balloon dilations over 10 weeks, followed by second series of balloon dilations, triamcinolone injections, and transanal advancement flap anoplasty</td>
</tr>
<tr>
<td>Kawaguti <em>et al</em>. 2015 Brazil [5]</td>
<td>1</td>
<td>Post-surgical- resection of rectal adenocarcinoma with temporary ileostomy, followed by colorectal anastomosis- 1/1</td>
<td>DNA</td>
<td>DNA</td>
<td>DNA</td>
<td>Colorectal anastomosis</td>
<td>None</td>
</tr>
<tr>
<td>Dieruf <em>et al</em> 2001 USA [6]</td>
<td>1</td>
<td>Post-surgical for sigmoid volvulus- 1/1</td>
<td>DNA</td>
<td>12 years</td>
<td>Inability to pass upper endoscope</td>
<td>1. Anastomotic site 2. Distance from anal verge: 20 cm</td>
<td>1. BD to 18 mm, using standard technique and inflation of 45 lbs per sq inch pressure</td>
</tr>
<tr>
<td>Kwon <em>et al</em> 2014 Korea [7]</td>
<td>2</td>
<td>Post-surgical- low anterior resection (LAR) for rectosigmoid colon cancer- 1/2</td>
<td>DNA</td>
<td>7-8 months (m)</td>
<td>1. Inability to pass sigmoidoscope 2. CT scan - less than 1 cm length of stenosis without any tumor recurrence</td>
<td>Colorectal anastomosis</td>
<td>None</td>
</tr>
<tr>
<td>Osera <em>et al</em> 2014 Japan [8]</td>
<td>7</td>
<td>Post-surgical- Intersphincteric resection (ISR) for lower rectal cancer- 4/7</td>
<td>DNA</td>
<td>Median: 11 m Range: 5-44 m</td>
<td>1. Inability to pass 9.2 mm endoscope or finger 2. Refractory anastomotic stricture: Severe stricture not relieved after two sessions of bougie or balloon dilatation (BD)</td>
<td>Colorectal anastomosis</td>
<td>Balloon or Bougie dilatation more than twice</td>
</tr>
</tbody>
</table>

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### Table 2 (Continued)

<table>
<thead>
<tr>
<th>Author/Year/Location</th>
<th>Number of Subject</th>
<th>Stricture etiology</th>
<th>Details of anastomotic closure</th>
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<tbody>
<tr>
<td>Truong et al 1997 Germany [12]</td>
<td>36</td>
<td>Post-surgical- right and left hemicolectomy, sigmoid resection, LAR of rectum- 36/36</td>
<td>1. Stapling device- 24/36 2. Suture-hand anastomosis- 12/36</td>
<td>Range: 3-12 m</td>
<td>1. Stricture criteria not reported 2. Three grades of stenosis- (a) Grade 1: Diameter 10-20 mm, occasional abdominal cramps- 21/36 (b) Grade 2: Diameter 5-9 mm, frequent abdominal cramps - 10/36 (c) Grade 3: Diameter&lt;5 mm, clinical signs of bowel obstruction- 5/36</td>
<td>1. Anastomotic site a) End to end- 36/36</td>
<td>None</td>
</tr>
</tbody>
</table>
In subjects experiencing symptoms of obstruction as a result of strictures, an immediate evidence of a successful technique was described as the ability to pass the endoscope through the stenosis site [9,10,13]. In subjects experiencing symptoms of obstruction as a result of strictures, an immediate evidence of a successful technique was described as the ability to pass the endoscope through the stenosis site [9,10,13].

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<th>Author/Year/Location</th>
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<th>Stricture location</th>
<th>Previous interventions done to treat the stricture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schubert et al 2003 Germany [13]</td>
<td>15</td>
<td>Post-surgical- gastrectomy and esophagectomy, esophagectomy and mediastinal esophagegastrostomy, esophagectomy and colon interposition - 15/49</td>
<td>Circular stapling device - 41/49</td>
<td>Range: 4-8 m</td>
<td>1. Endoscopy and barium swallow or enema: Stricture causing symptoms and/or diameter&lt;10 mm or at high risk for imminent ileus 2. Mean length - 6.1 mm (Range: 3-10) 3. Mean diameter - 5.2 mm (Range: 3-8)</td>
<td>1. Anastomotic site None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>Post-surgical- LAR, left hemicolectomy, subtotal colectomy and ileorectostomy - 34/49</td>
<td>Range: 4-8 m</td>
<td>1. Anastomotic site 2. Distance from anal sphincter: 5-16 cm</td>
<td></td>
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</tbody>
</table>

**Outcome**

Outcomes were broadly classified based on the alleviation of symptoms and/or endoscopic evidence of absence of restenosis. Outcomes were broadly classified based on the alleviation of symptoms and/or endoscopic evidence of absence of restenosis.

In the retrospective case series by Schubert et al [13], the majority of patients underwent a single inpatient procedure, with the median length of hospital stay being 3 days. In the prospective study by Brandimarte et al [10], the procedure was performed using sphincterotome and bimodal electrocautery to make six radial incisions, the length and depth of which were operator dependent.

EECI with adjunctive corticosteroid injection was performed by Dieruf et al [6]. A 5-Fr needle knife was used to make incisions in four quadrants, with each cut being 5-8 mm in depth, resulting in a 20 mm luminal diameter. This was followed by injecting 7-10 mg of triamcinolone at each incision site using a sclerotherapy needle, up to a total of 35 mg.

EECI in combination with balloon dilation was described in two prospective studies [11,12]. Hagiwara et al used an endoscopic diathermic knife and a balloon dilator [11]. Two to three shallow radial incisions were made using repeated, short bursts in the stricture scar. A flexible tipped guide wire was then inserted, over which a balloon dilator was positioned at the stricture under fluoroscopy. Water-soluble contrast medium was used to inflate the balloon, which was then pulled out to have the stricture aligned in the middle. The balloon was left for 15-20 min and resulted in loosening of the scar. Of the five patients in this study, two who had a diverting colostomy underwent two sessions a week for two weeks and the remaining three patients, without a colostomy, had one treatment session only in another prospective study by Huang et al [12]. The type of incision was dependent on whether the stenosis was central or eccentric. A higher number of consecutive dilatations were needed for a higher grade of stenosis.

Subjects enrolled in the prospective study by Schubert et al underwent incisions by a polypectomy snare, followed by reduction of the scar tissue in between the incisions by APC [13]. No more than one therapeutic session was needed for all subjects.

Details of the instruments used and techniques performed in each study have been summarized in Table 3.
### Table 3: Instruments and technical details for intervention in each study

<table>
<thead>
<tr>
<th>Author/ Year/ Location</th>
<th>Study Type</th>
<th>Number of subjects</th>
<th>Type of intervention</th>
<th>Instruments used</th>
<th>Technique details</th>
<th>Additional findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kawaguti et al. 2015 Brazil [5]</td>
<td>Case report</td>
<td>1</td>
<td>Endoscopic electrocautery radial incision and cutting (RIC)</td>
<td>1. Insulated- tip knife (KD611L; Olympus, Tokyo, Japan) 2. Electrosurgical ERBE VIO (ERBE Elektromedizin, Tübingen, Germany) unit in endocut mode</td>
<td>1. Incisions- Radially with resection of tissue between incisions 2. Duration- 12 min</td>
<td>None</td>
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<tr>
<td>Dieruf et al 2001 USA [6]</td>
<td>Case report</td>
<td>1</td>
<td>Endoscopic electrocautery incision with adjunctive corticosteroid injection</td>
<td>1. Standard colonoscope 2. 5F needle knife (Wilson-Cook Medical, Inc., Winston-Salem, NC) 3. Sclerotherapy needle</td>
<td>1. Incision: (a) In 4 quadrants with 30 J energy (b) Depth of cut 5-8 mm 2. Estimated residual luminal diameter 20 mm 3. Injected 7-10 mg (total of 35 mg) triamcinolone at the base of each incision with sclerotherapy needle</td>
<td>None</td>
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<tr>
<td>Kwon et al 2014 Korea [7]</td>
<td>Case series</td>
<td>2</td>
<td>Endoscopic electrocautery incision</td>
<td>1. 12 mm colonoscope (CV-260 SC; Olympus Optical Co, Tokyo, Japan) + 3.2 mm operative channel 2. IT- knife (KD-612U; Olympus) + 1.7 mm diameter tip 3. 2.5 mm needle 4. Bimodal electrocautery, ERBE (300D; ERBE Elektromedizin GmbH, Tübingen, Germany) unit with endocut Q mode</td>
<td>1. Incision- (a) Length and depth gauged by endoscopist according to stricture length and caliber- verified by CT and colonoscopy (b) Depth not deeper than muscular layer 2. Duration- 5-10 min</td>
<td>None</td>
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<tr>
<td>Osera et al 2014 Japan [8]</td>
<td>Case series</td>
<td>7</td>
<td>Endoscopic electrocautery RIC</td>
<td>1. 9.2 mm endoscope (GIF Q260; Olympus Medical Systems, Tokyo, Japan) 2. Insulated- tip IT knife (Olympus Medical Systems)</td>
<td>1. Incision- Radially with excision of scar tissue in an arc from the incision along the lumen 2. Median duration- 18 min (Range: 7-34)</td>
<td>1. Total Number of RIC sessions: 16 for 7 subjects a) One session- 4/7 b) Two session- 1/7 c) Four session- 1/7 d) Six session- 1/7 2. Setting of RIC: (a) Inpatient: 14/16 (b) Outpatient: 2/16 3. Median hospital stay- 3 days (Range: 2-5)</td>
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<table>
<thead>
<tr>
<th>Author/Year/Location</th>
<th>Study Type</th>
<th>Number of subjects</th>
<th>Type of intervention</th>
<th>Instruments used</th>
<th>Technique details</th>
<th>Additional findings</th>
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</table>
| Bravi et al 2015     | Case series | 60                | Endoscopic electrocautery incision | 1. Standard colonoscope (EC-3885FK/EC-3890Fi, Pentax, Tokyo, Japan) 2. Precut sphincterotomy (KD-10Q-1, Olympus, Tokyo, Japan) | 1. Incision-  
   (a) Not less than 4 radial incisions  
   (b) Length and depth decided by endoscopists  
   2. Performed by 2 expert endoscopists (15 years experience) | 1. Number of treatment sessions: 60 sessions for 60 subjects |
| Brandimarte et al 2000 | Prospective study | 39                | Endoscopic electrocautery RIC | 1. 12 mm videocolonscope (Fujinon EC 300, Omiya, Japan) 2. Sphincterotomy (Precut MTW, MTW Endoskopie, Wesel, Germany) 3. Bimodal electrocautery, Soring 600 instrument (Söring Medizintechnik, Quickborn, Germany) set on “blend” at 2 | 1. Incision-  
   (a) 6 radial incisions made with sphincterotomy  
   (b) Length of cut gauged by endoscopist according to stricture length and caliber- described by barium enema  
   (c) Depth of cut compared with width of open jaws of biopsy forceps (8 mm) | None |
| Hagiwara et al 1999  | Prospective study | 5                 | Endoscopic electrocautery incision and dilation | 1. Sigmoidofiberscope 2. Endoscopic diathermic knife (electrocautery sphincterotomy knife, KD-1L, Olympus Optical, Tokyo, Japan) 3. Balloon dilator (Rigiflex, Boston Scientific, Watertown, MA, USA) | 1. Incision: 2-3 shallow radial incisions via a 3 second burst  
   2. Under fluoroscopy, proximal end of balloon dilator was positioned at the stricture site and inflated  
   3. Balloon was left for 15-20 mins so the scar was loosened | 1. Number of treatment sessions:  
   (a) Two at 2 week interval: with colostomy  
   1. Number of treatment sessions:  
   (b) One: without colostomy |
| Truong et al 1997    | Prospective study | 36                | Endoscopic electrocautery incision and consecutive hydraulic balloon dilatation | 1. 12 mm flexible endoscope 2. Sphincterotomy 3. Polypectomy snare 4. Balloon dilator (25 mm Rigiflex BD) or a hydraulic BD | 1. Incision-  
   Radially with sphincterotomy or tip of polypectomy snare  
   a) Central stenosis: 4 incisions  
   b) Eccentric stenosis: Variable, at site of maximal scar formation  
   2. BD- balloon inflated to 35 PSI and left for 3 min | 1. Number of consecutive dilatations-  
   (a) Grade 1: one for 21/21 subjects  
   (b) Grade 2: 2 for 6/10 subjects; 1 for 4/10 subjects  
   (c) Grade 3: 3 for 5/5 subjects  
   2. Hospital stay for 2 days for all patients |

(Contd...)
the anastomotic strictures, relief of symptoms like constipation, abdominal distension or abdominal pain was also considered a positive outcome measure for success of the technique. Serial follow ups were performed in all studies included in the review; they included evaluation of symptoms, digital palpation exams, endoscopic visualization and/or barium enema. The duration of follow up was variable, from a minimum of 8 months to a maximum of 12 years [7,9].

Success

All ten studies together had 186 subjects with lower gastrointestinal tract benign anastomotic stricture who underwent EECI, either alone or in combination with another treatment modality. Individually, 63 subjects underwent EECI alone [4,7,9]; 47 subjects underwent endoscopic electrocautery with RIC [5,8,10]; 41 subjects underwent combination therapy with EECI and balloon dilation [11,12]; 34 subjects had combination therapy with EECI and steroid injection [6]; and 1 subject had combination treatment with EECI and APC [13]. The overall success rate for early post procedure and on long-term follow up was 98.4% (183/186) and 93.0% (173/186), respectively. On long-term follow up, the success rate for EECI alone was 95.2% (60/63), for EECI with RIC it was 95.8% (45/47) and for combination treatment with EECI and balloon dilation it was 87.8% (36/41). Individual studies of combination treatment by EECI and steroid injection or APC reported success rates of 91.2% and 100%, respectively [6,13]. Six studies reported a 100% success rate on long-term study-specific follow up [4-7,10,11].

Of 186 total subjects, 14 had a refractory stricture and 172 were treatment-naive. Among the subjects with a refractory stricture, the success rate both early post-procedure and over long-term follow up was 85.7% (12/14). Among treatment naïve subjects, the early post-procedure and long-term success rates were 99.4% (171/172) and 93.6% (161/172) respectively. Figure 1 and 2 depicts EECI of a benign colon stricture.

Failure

EECI, alone or in combination with another treatment modality, failed to achieve stricture dilation in 1.6% (3/186) of the total population [4-13]. All studies except two reported a failure rate of 0% in achieving post-intervention stricture dilation [4-13]. Osera et al reported that 2 of 7 subjects (28.6%) failed to achieve stricture dilation, despite 4 and 6 sessions of endoscopic electrocautery with RIC, respectively [8]. In another study, the operator was unable to perform EECI and balloon dilation in 1 of 36 subjects (2.8%), because of a lack of epithelialization of the stricture that increased the risk of perforation [12].

Stricture recurrence

Restenosis or recurrence of anastomotic stricture was identified as a result of development of symptoms and/or
identification during follow-up endoscopic procedures. Bravi
et al reported a 5% (3/60) recurrence rate [9]. This was noted
in three asymptomatic subjects; two were successfully treated
with a single electrocautery dilatation and one was treated with
a single session of Savary-Gilliard bougie dilatation. Notably,
in one of the subjects the primary anastomotic closure was
performed using a circular stapling device. Truong et al had
a stricture recurrence rate of 14.3% (5/35) [12]. Two patients
who initially had a grade II stenosis and one patient with a
grade III primary stenosis had a recurrent grade I restenosis;
all were treated with a single balloon dilatation. Two patients
with primary grade III stenosis were found to have grade II
restenosis, which required two consecutive balloon dilatation
procedures with no further recurrences on follow up. Schubert et al had a recurrence rate of 8.8% (3/34) for lower
gastrointestinal tract strictures [13]. All subjects required a
mean number of 3.5 endoscopic sessions for treatment.

The stricture recurrence rate for subjects undergoing EECI
alone was 4.8% (3/63), for endoscopic electrocautery with RIC
it was 0% (0/45) and for combination therapy with EECI and
balloon dilatation it was 12.5% (5/40). In our opinion, balloon
dilatation in combination with EECI is likely to cause more
edema, which disrupts the healing of the incision site and leads
to a higher recurrence rate. Overall, the stricture recurrence
rate for the cohort was 6.0% (11/183). The recurrence rate
demonstrated in our cohort was much lower than that reported
for balloon dilation alone (18%) [3].

Complications

In comparison with standard treatment procedures for
anastomotic strictures, such as balloon dilation, endoscopic
incision techniques have been shown to have lower rates of
perforation. In our review, eight studies reported a
complication rate of 0% [4-11]. Of a total 186 subjects, only
7 (3.8%) reported abdominal pain post-procedure. No
other complication (bleeding, infection or perforation) was
reported [4-13]. Schubert et al. described 6 subjects (12.3%)
reporting some transitory abdominal pain [13]. Subjects were
monitored for one day and discharged without any events,
requiring no other intervention. Local abdominal pain was
also described in 1 patient (2.8%) by Truong et al [12]. It was
attributed to the finding of a post-dilatation anastomotic ulcer,
which healed with conservative management.

Concluding remarks

The incidence of benign colorectal anastomotic strictures is
on the rise. The current standard for managing such strictures
is primarily endoscopic balloon dilation therapy. The major
pitfall of this modality is its high stricture recurrence rate
and risk of perforation. The EECI technique, either alone or
in combination with alternative treatment modalities such
as steroid injection, balloon dilation or APC, is a promising
new tool to treat both treatment-naive and refractory
strictures. In our review, the overall success rate for EECI-
based interventions for benign lower gastrointestinal tract
strictures was 98.4%, with a stricture recurrence rate of 6.0%
and a composite complication rate of 3.8%. The high success
rate, lower stricture recurrence rate and lower incidence of
complications in comparison to endoscopic balloon dilatation
therapy make EECI the preferred option for short non-
inflammatory strictures. Head-to-head randomized controlled
trials comparing EECI to endoscopic balloon dilation therapy
are awaited before it can be considered as the standard therapy
for the management of benign colorectal strictures.

References


**Author Query**

**AQ1:** Kindly cite figure 1 and 2 in text part