Revista Española de Enfermedades Digestivas
THE SPANISH JOURNAL OF GASTROENTEROLOGY

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DOI: 10.17235/reed.2018.5598/2018
Link: PubMed (Epub ahead of print)

Please cite this article as:
Rubín de Célix Vargas Cristina, Martín García Paula, del Campo Lourdes, García-Buey Luisa. String sign of Kantor in a patient with Crohn's disease. Rev Esp Enferm Dig 2018. doi: 10.17235/reed.2018.5598/2018.

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CE 5598 inglés

String sign of Kantor in a patient with Crohn's disease

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CASE REPORT

We report the case of a 29-year-old male with structuring ileocolic Crohn's disease (CD), diagnosed in 2007 and treated with oral azathioprine, oral mesalazine and intravenous infliximab, without any other surgical or medical history of interest. He presented to the Emergency Room with abdominal distention and pain, nausea, vomiting and motility problems of a three-day duration. An abdominal computerized tomography using intravenous contrast was performed (Figs. 1 and 2).

The stenosis was *de novo*, with a predominance of fibrostenotic strictures, wider than 5 cm in length. Thus, medical treatment or endoscopic intervention could not be performed. Finally, the patient required surgery; an extended right hemicolectomy was performed. There were no complications after the procedure.

DISCUSSION

Stricturing CD can be classified according to whether or not there is a previous history of surgery (*de novo* or anastomotic) and according to the composition of strictures (inflammatory, fibrotic and mixed types) (1). It is the second indication for surgery, after failure of medical treatment. The approach to stricturing CD includes endoscopic balloon dilation and metallic biodegradable or removable stents, when the stenosis is less than 5 cm in length or there is an anastomotic postoperative recurrence stenosis. Surgery including strictureplasty and intestinal resection may also be performed. The latter must be as minimally invasive as possible and focused on relieving the stenosis (2,3).

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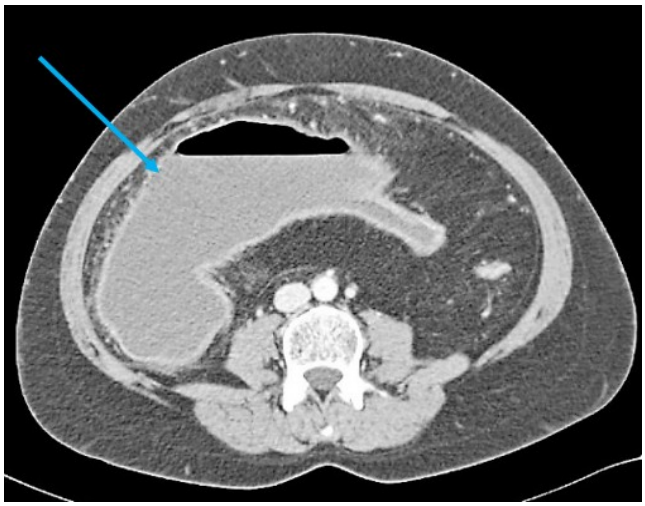

Fig. 1. Significant transverse colon dilatation (7 cm) with air-fluid level and inflammatory changes in the pericolic fat (blue arrow).

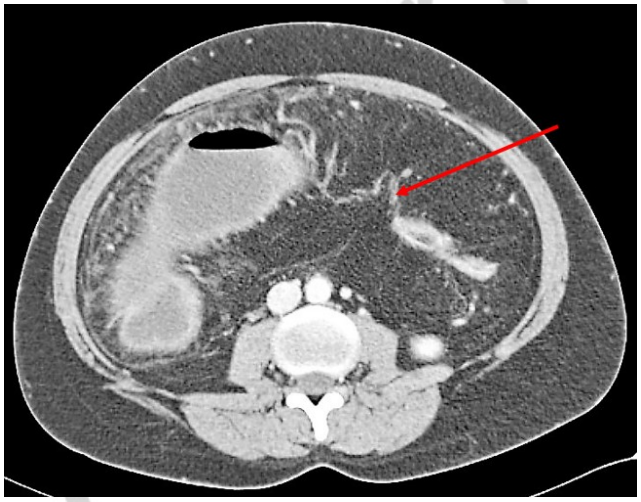

Fig. 2. An 8 cm stenotic bowel in the splenic flexure is seen in the distal bowel; the image of string sign of Kantor is shown (red arrow).