

Background: In the late 1980s after the first successful laparoscopic cholecystectomy in Europe, this minimally invasive surgery rapidly became the accepted technique for the treatment of gallbladder disease in the United States of America. The rapid acceptance of this new technique by the medical profession and the public was related to the obvious advantages of reduced cost, decreased hospital length of stay, and increased patients' satisfaction (Nezam H Afdhal *et al.*, 2017). Common bile duct (CBD) injuries are the most serious and feared complications of laparoscopic cholecystectomy since they cause substantial morbidity and increased hospital stay and increasingly often are the subject of legal disputes (Chir Ital., 2007). Recommendation, according to the last update as well known in the literatures, for the management of complications of cholecystectomy in biliary duct injuries should always be approached by an experienced multidisciplinary team consisting of surgeons, interventional gastroenterologists, and interventional radiologists. **Methods:** Patients presented at any time with different types of postcholecystectomy biliary injury and posthepaticojejunostomy complications were subjected to intervention radiological procedures with and/or without endoscopic-radiologic rendezvous. **Results:** We succeeded to manage 840 cases of postcholecystectomy biliary injury (783 cases) and posthepaticojejunostomy complications (57 cases) by percutaneous transhepatic biliary access, throughout more than 20 years starting in October 1995 when we had established the 1st intervention unit in upper Egypt, at Assiut University Hospital, and lately in other institutional centers in the Kingdom of Saudi Arabia. **Conclusion:** Biliary injuries or complications, following cholecystectomy or postcholecystectomy, usually can be treated within tertiary referral hepatobiliary multidisciplinary center, and major surgery can be avoided and performed only in selective conditions.

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Percutaneous Endoscopic Gastrostomy Large-Bore Tube Application without the Use of Endoscope: Single-Center Experience on 86 Neurologically Compromised Patients

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Background: Despite being an established method of enteral feeding, percutaneous fluoroscopic-guided small-bore push gastrostomy tubes are more prone to tube occlusion and dislodgement. This study describes an adapted alternative of nonendoscopic technique to apply large-bore mushroom-head gastrostomy tubes originally designed to be applied endoscopically. **Methods:** Between January 2015 and November 2017, 86 gastrostomy tubes were placed in 86 neurologically compromised patients. 24F mushroom-head tubes were used. The stomach was filled with air via nasogastric tube through which a Dormia basket or a large Snare was introduced. A 16G Angiocath was advanced through a skin puncture into the Dormia basket at the gastric body level through which bifid guidewire was extracted by the Dormia basket or the snare. The gastrostomy tube was bound to the wire and pulled under fluoroscopic guidance. Technical success and procedural

complications were assessed and regular follow-up was done to ensure tube function and monitor complications. **Results:** A 100% technical success was achieved defined as successful positioning of the stent, bypassing the leakage. Distal migration occurred twice in the same patient with balloon repositioning. Persistence of the leakage after stent removal took place in four patients (all were referred late 20 days plus postsurgery), three of which had re-surgery and one patient who had residual tubular cutaneous-anastomosis fistula had track coiling with cessation of leakage. **Conclusion:** Fluoroscopic-guided esophageal stenting might be effective in bypassing anastomotic leakages following bariatric surgeries; however, it should be considered as soon as significant leakage is diagnosed and should be considered before re-surgery. Placement of the stents was feasible without major procedure-related complications.

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Role of Computed Tomography-Guided Percutaneous Celiac Plexus Neurolysis in Relieving Pain Due to Abdominal Malignancy

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Background: Cancer-related pain remains a common problem in oncologic practice and has major influence on patient's comfort, tolerance of therapies, and probably survival. This study aims to assess the efficacy of Computed tomography (CT)-guided celiac plexus neurolysis (CPN) to relieve pain in patients with advanced abdominal cancer. **Methods:** CT-guided CPN through anterior technique was done for 20 adult patients (their ages ranges between 30 and 70 years) suffering from abdominal cancer pain using ethanol (90%) as a neurolytic agent. To assess the degree of pain relief, the visual analog score (VAS) was used to assess the degree of pain; immediately after injection, 1 week, 1 month, and 3 months' post-CPN procedure. **Results:** Marked decrease of the pain intensity in all the patients was noted as a sharp fall of the VAS score immediately after injection of the neurolytic agent and more pronounced in the 1st day post-CPN with the relatively stationary course for 3 months. The VAS score base line was 9.1 ± 0.85 . One day after CPN, pain severity decreased markedly to 1.3 ± 0.71 , 1 week later, the decrease in pain severity almost maintained at the same level 1.7 ± 0.89 , 1 month after CPN, the decrease in pain severity also maintained at the same level 1.9 ± 0.79 and 3 months after CPN pain severity still decreased significantly to 2.3 ± 1.02 . The decline in the severity of pain at its average before and at different sequences after CPN recorded high significant statistical difference $P < 0.001$. **Conclusion:** CT-guided CPN is an effective and safe method for relieving severe pain due to abdominal cancer.