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The Outcomes of Percutaneous Transhepatic Cholangiography for the Palliation of Malignant Jaundice in England Between 2001 and 2014

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Background: Relieving obstructive jaundice in patients with inoperable pancreaticobiliary cancers improves quality of life and permits palliative chemotherapy. Percutaneous transhepatic cholangiography (PTC) with biliary drainage and/or biliary stenting and are commonly used to relieve obstructive jaundice in such patients, and we have examined outcomes of PTC in a national patient cohort. **Methods:** A retrospective cohort study of all patients undergoing PTC as part of palliative therapy of pancreaticobiliary cancer in England between April 2001 and March 2014, identified from Hospital Episode Statistics. Multivariate logistic regression analysis was used to examine associations with mortality. **Results:** A total of 16,822 individuals undergoing PTC were analyzed (median age 72 [range 19–104], 50.3% males). About 58% had pancreatic and 30.1% had biliary tract cancer. In-hospital and 30-day mortality was 15.3 (95% confidence interval 14.7%–15.9%) and 23.1 (22.4%–23.8%), respectively. About 36% suffered a complication: sepsis (16.5%), stent blockage or displacement (6.4%), and acute kidney injury (4.7%). Thirty-day mortality was associated with increasing age (81+ odds ratio 2.68 [2.37–3.03], $P < 0.001$), comorbidity (Charlson score 20+, 3.10 [2.64–3.65], $P < 0.001$), and preexisting renal dysfunction (2.37 [2.12–2.65], $P < 0.001$), increasing deprivation (1.28 [1.13–1.44], $P < 0.001$), and cancer type other than pancreatic (unspecified biliary tract 1.28 [1.08–1.52], $P = 0.004$). Females had a better prognosis (0.91 [0.84–0.98], $P = 0.011$), as did those undergoing PTC in a “high-volume” provider (84–180 PTCs 0.68 [0.58–0.79], $P < 0.001$). **Conclusion:** In subjects undergoing PTC for the palliative relief of malignant jaundice, 30-day mortality is 23.1% and complications occur in 36%. Mortality is higher in older males, those with increasing comorbidity and when the procedure is carried out by operators performing low volumes of PTC.

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Minimally Invasive Treatment of Benign Gallbladder Pathology in Nonsurgical Candidates: Cystic Duct Stenting

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Background: M. R. Akhtar, A. Zaman, T. Fotheringham; Acute cholecystitis in critically ill patients carries a high mortality rate. Patients who are unresponsive to medical management and unsuitable for immediate cholecystectomy require an

interventional solution. Percutaneous cholecystostomy is an effective bridging therapy providing immediate symptom control until surgery. A subgroup of patients with severe comorbidities will never be suitable for surgery; these patients can become dependent on long-term external drainage to avert recurrent cholecystitis. Percutaneous cystic duct (cholecystoduodenal) stenting offers a solution to internalize these drains in both delayed surgical candidates and nonsurgical candidates. We present our series with a long-term follow-up demonstrating the benefits of this procedure. **Methods:** Eleven patients unfit for surgery in our institution underwent cystic duct stent insertion for the management of acute cholecystitis from July 2009 to April 2017. A two-stage procedure involved an initial percutaneous transhepatic cholecystostomy and a subsequent cystic duct stent insertion. An 8 Fr $\times$ 16 cm transplant ureteric stent was positioned with the proximal loop in the gallbladder and the distal loop in the duodenum. The cholecystostomy drain was removed at a later date after a check cholangiogram. **Results:** One patient presented with gallbladder perforation, seven patients with acute cholecystitis, one with gangrenous cholecystitis, and two patients with gallbladder empyema. Ten cases were successful at the first attempt. One case was unsuccessful (unfavorable cholecystostomy site for the second stage) second attempt not performed as the clinical team decided on a different management plan. The technical success rate was 91% and no immediate major complications. **Conclusion:** Cystic duct stenting has a high technical success rate with a low rate of complications. The good clinical outcome with no reintervention. This series has also demonstrated a wider indication of benign diseases for this procedure. Cystic duct stenting should be considered as a temporary and long-term option in critically ill-cholecystitis patients.

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Removal of Embedded Tunneled Hemodialysis Catheters Using Endoluminal Balloon Dilatation: A Single-Center Experience

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Background: Increasing frequency of tunneled hemodialysis catheter usage increases the burden for removal or exchange. A small proportion of dialysis catheter failed to be removed by conventional techniques. **Methods:** We retrospectively report a series of 12 cases in our institution between September 2015 and December 2017 who failed removal of tunneled dialysis catheters by conventional methods. The study cohort included 11 males and 1 female with mean age of 44 (12–90 years). The mean catheter dwelling time was 770 (153–1442 days). Reason for catheter removal included dysfunctional catheter ($n = 5$), line sepsis ($n = 4$), and switching to functioning fistula ($n = 1$). Catheter types included GlidePath Bard ($n = 2$), Vaxel Boston Scientific ($n = 2$), HemoStar Bard PV ($n = 2$), Palindrome Medtronic ($n = 2$), Equistream Bard ($n = 1$), Medcomp ($n = 1$), and unknown catheter. The insertion sites were internal jugular vein ($n = 11$)