Peroral antegrade pancreatoscopy for pancreaticolithiasis after endoscopic ultrasound-guided recanalization of a complete pancreaticojejunal stenosis

Pancreatoduodenectomy may result in symptomatic pancreaticojejunal stenosis in 2%–10% of cases [1]. As an alternative to surgery, endoscopic pancreatic duct decompression may be performed by retrograde (enteroscopy) or antegrade (endoscopic ultrasound [EUS]-guided transgastric access) approach [2]. The latter is more likely to be technically successful (up to 70% of cases) [3], and also enables anastomotic recanalization [4]. For pancreaticolithiasis treatment, an antegrade pancreatoscopy procedure has been recently described as feasible and useful [5].

We herein describe the case of a 51-year-old woman who presented with abdominal pain and several episodes of mild pancreatitis in the preceding 12 months. Symptoms were due to a pancreaticojejunal stenosis and obstructing pancreatic ductal stones following a curative pancreaticoduodenectomy performed 8 years earlier (Fig. 1). After a previous EUS-guided attempt failed because of complete pancreaticojejunal stenosis, a successful EUS-guided pancreatic recanalization was achieved in June 2017, which enabled the placement of a transgastric indwelling double-pigtail stent across the stenosis (Fig. 2, Fig. 3, Video 1). The patient became asymptomatic.

In March 2018, it was decided to perform a peroral transgastric pancreatoscopy to evaluate a persistent pancreaticojejunal stenosis and treat any remaining ductal stones. After stent removal and endoscopic dilation of the stenosis and gastric tract (Fig. 4), a digital single-operator peroral cholangioscope (SpyGlass DS, Boston Scientific, Marlborough, Massachusetts, USA) was inserted through a standard therapeutic duodenoscope into the pancreatic duct until it reached...
The jejunum (Fig. 5, Video 1). This revealed a fibrotic pancreaticojejunal stenosis, 3 cm in length, and a persistent pancreatic ductal stone, 4 mm in size (Fig. 6). Pancreatic ductal clearance was achieved using water irrigation and push-and-pull maneuver, with no need for intraductal lithotripsy. A 10 Fr 12 cm transgastric plastic biliary stent was placed across the stenosis.

The patient was discharged the day after the procedure and continued to do well 60 days later. This patient will need further stent replacement until a desirable and stable pancreaticojejunal opening is achieved.

Endoscopy_UCTN_Code_TTT_1AR_2AB
Competing interests
None

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DOI https://doi.org/10.1055/a-0677-1623
Published online: 10.9.2018
Endoscopy 2018; 50: E333–E335
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

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Fig. 6 Pancreatography confirmed a persistent 4 mm pancreatic ductal stone (red arrow), which was suspected at pancreatography (a). A guidewire can be seen in the pancreatic duct (blue arrow).

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