Bridge-to-surgery gallbladder drainage with a lumen-apposing metal stent in malignant distal biliary obstruction: a choice tailored for the surgeon

A 70-year-old woman with cholangitis was diagnosed with a distal biliary stricture at another institution. The patient was referred to our center for biliary decompression and further evaluation. Endoscopic ultrasound (EUS) examination revealed wall thickening in the lower third of the common bile duct (CBD) and an intraluminal inhomogeneous hypoechoic lesion with irregular margins infiltrating the duodenal wall and the major papilla (▶Fig. 1). The gallbladder was distended, and the middle/upper third of the CBD was dilated up to 2 cm in diameter, with associated intrahepatic biliary tree dilation. Endoscopic retrograde cholangiopancreatography (ERCP) was unsuccessful owing to duodenal infiltration.

In order not to hamper a theoretical subsequent surgical biloenteric anastomosis (in the setting of a duodenopancreatectomy) we decided not to proceed with EUS-guided bile duct drainage (EUS-BD), even if technically feasible. In fact, an EUS-guided choledochoduodenostomy would have altered the integrity of the middle/upper third of the CBD, potentially conditioning future surgery, in case of resectability. Considering this, we opted for EUS-guided gallbladder drainage (EUS-GDB) from the gastric antrum with an 8 × 8 mm electrocautery-tipped lumen-apposing metal stent (LAMS) (AXIOS-EC; Boston Scientific, Marlborough, Massachusetts, USA) in a freehand fashion. Same-session EUS-guided fine-needle biopsy confirmed malignancy of the lesion and a computed tomography scan assessed resectability (▶Fig. 2). The patient underwent Whipple duodenopancreatectomy 2 weeks later (▶Fig. 3 a, b, ▶Video 1). Histologic assessment diagnosed a pT2/N2/Pn1/R0 poorly differentiated adenocarcinoma, and the post-operative course was uneventful.

ERCP and EUS-BD in patients with unresectable distal biliary stricture [1]. In resectable malignant distal biliary strictures, EUS-GBD using an LAMS is a feasible bridge-to-surgery treatment if biliary decompression is needed. Actually, this technique preserves the integrity of the CBD, allowing the surgeon to perform a standard Whipple resection and a safe biloenteric anastomosis.

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Competing interests
None

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