A 72-year-old woman, who was unfit for surgery, was admitted with recurrent cholangitis. She had a history of cholecystectomy and side-to-side choledochoduodenostomy (CDD) for huge impacted stones. In the previous year, she had undergone multiple endoscopic retrograde cholangiopancreatographies (ERCPs) with endoscopic sphincterotomy, incomplete stone extractions, and plastic stent placement in a local hospital. Magnetic resonance cholangiography showed multiple stones throughout the biliary tree, which was dilated up to 4 cm, along with an incarcerated plastic stent.

Endoscopy with a frontal-view scope (GIF-1TH190; Olympus Europe) confirmed a 25-mm CDD in the duodenal bulb (▶Fig. 1). Management of the huge impacted stones by conventional techniques was not feasible; therefore, a 1.9-Fr bipolar electrohydraulic lithotripsy probe (Autolith; Northgate Technologies Inc.) was passed through the working channel of the endoscope to break the stones under direct cholangioscopy guidance (▶Fig. 2). The scope channel allowed the removal of all fragments. Final fluoroscopy revealed a large diameter, atonic, empty biliary tree with delayed biliary outflow. A plastic stent was then inserted from the common bile duct to the duodenum, through the papilla, to promote drainage (▶Fig. 3).

The patient returned 1 month later because of cholangitis. Endoscopy revealed a large amount of food debris in the biliary reservoir; a diagnosis of sump syndrome was made. Complete extraction of the food matter was performed. In order to prevent the recurrence of duodencholedochal reflux, we decided to perform a stoma revision using the OverStitch device (Apollo Endosurgery; Austin, Texas, USA) to reduce the size of the CDD, leaving enough room for biliary outflow (▶Video 1). There were no post-procedural complications. The patient has remained asymptomatic during 1 year of follow-up (▶Fig. 4).

Sump syndrome is a rare long-term complication of CDD, with a reported prevalence of 2.5% [1]. Endoscopic sphincterotomy is the treatment of choice but, if endoscopic treatment fails, surgery is advisable [2]. Evidence concerning endoscopic closure of a CDD is lacking [3–5]. This is the first report detailing an endoscopic revision of a CDD using endoscopic suturing.

Endoscopy_UCTN_Code_TTT_1AR_2AG
Competing interests
None

The authors
Antonino Granata¹, Michele Amata¹, Alberto Martino¹, Dario Ligresti¹, Sergio Li Petri², Calogero Ricotta², Mario Traina¹
¹ Digestive Endoscopy Service, Department of Diagnostic and Therapeutic Services, IRCCS-ISMETT, Palermo, Italy
² Abdominal Surgery and Organ Transplantation Unit, Department for the Treatment and Study of Abdominal Diseases and Abdominal Transplantation, IRCCS-ISMETT, Palermo, Italy

Corresponding author
Antonino Granata, MD
Endoscopy Service, IRCCS-ISMETT, Via Tricomi 5, 90127 Palermo, Italy
Fax: +39-091-2192400 (specify Endoscopy Service)
agranata@ismett.edu

References

Bibliography
DOI https://doi.org/10.1055/a-0919-4318
Published online: 4.6.2019
Endoscopy 2019; 51: E337–E338
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at
https://mc.manuscriptcentral.com/e-videos

ENDOSCOPY 2019; 51: E337–E338

Video 1 Management of sump syndrome by electrohydraulic lithotripsy under direct cholangioscopy view and by choledochoduodenostomy revision using an endosuturing system.

Fig. 4 Follow-up endoscopic evaluation at 2 months showing a reduced caliber of the choledochoduodenostomy, with no evidence of lithiasis or food/debris inside.