A 75-year-old man with peritoneal recurrence of distal bile duct cancer after pancreaticoduodenectomy was admitted because of cholangitis. A computed tomography scan showed obstruction of the afferent limb by peritoneal metastasis and intrahepatic bile duct dilatation without stricture at the hepaticojejunostomy (Fig. 1). After the patient’s cholangitis had resolved with percutaneous transhepatic biliary drainage (PTBD), placement of a self-expandable metal stent (SEMS) was planned across the malignant afferent limb stricture through the PTBD route under fluoroscopic guidance. However, a guidewire could not be passed through the stricture because of the tightness of the stricture and the dilated proximal afferent limb (Fig. 2a). Therefore, once the PTBD route had matured, we inserted the digital cholangioscope (SpyGlass DS Direct Visualization System; Boston Scientific Japan, Tokyo, Japan) through the bile duct. Guidewire passage was easily achieved under direct visualization (Fig. 2b), and a SEMS was successfully placed across the stricture (Fig. 2c; Video 1).

Recently, there have been strategies reported for non-surgical management of afferent loop syndrome [1, 2], especially using a lumen-apposing metal stent (LAMS) under endoscopic ultrasound (EUS) guidance [3, 4]. While a LAMS provides safety owing to its one-step procedure, it is not commercially available for this purpose in many countries. Furthermore, EUS-guided gastrojejunostomy carries a potential risk of bleeding or peritonitis if performed in the presence of other digestive tract lesions.
of active cholangitis. Therefore, in patients with concomitant cholangitis, PTBD is often performed as the initial drainage procedure. The PTBD route can then potentially be used to relieve afferent loop syndrome, but guidewire passage across the stricture is technically challenging.

We previously reported the use of digital cholangioscopy as an effective modality for guidewire passage across a complex biliary stricture [5] and we used the same approach for management of this malignant afferent limb stricture. In summary, guidewire manipulation under direct visualization using digital cholangioscopy has proved effective in patients in whom guidewire passage has failed under fluoroscopic guidance, including in the presence of an afferent limb stricture.

Competing interests
None

The authors
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References

Bibliography
DOI https://doi.org/10.1055/a-0999-5204
Published online: 2019
Endoscopy
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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Fig. 2 Radiographic images showing: a the guidewire, which could not be placed across the malignant stricture of the afferent limb under fluoroscopic guidance (the anastomosis of the hepaticojejunostomy arrow was widely open); b the guidewire successfully placed through the stricture of afferent limb using digital cholangioscopy; c a self-expandable metal stent successfully positioned across the malignant afferent limb stricture.