Endoscopic resection of a choledochocele

Choledochal cysts are uncommon congenital dilatations of the extrahepatic and/or intrahepatic biliary system. Several serious complications of choledochal cysts have been described, including malignancy. According to Todani et al., choledochal cysts are classified into five types [1]. Type III, or choledochocele, is a cystic dilatation of the intra-ampullary portion of the common bile duct (CBD). Compared with other choledochal cysts, the choledochocele has a very low rate of malignant transformation [2]. Therefore, the choledochocele can be treated with sphincterotomy or endoscopic papillectomy [3,4]. Here we report a case of a 17-year-old man admitted to our hospital with acute mild pancreatitis.

A preliminary magnetic resonance cholangiopancreatography showed an isolated cystic-like dilatation of the distal portion of the CBD. Duodenoscopy revealed a 25–30-mm subepithelial swelling proximal to the major papilla and protruding into the duodenum (▶Fig. 1). Endoscopic ultrasound confirmed cystic dilatation of the intra-ampullary portion of the CBD and three biliary stones. Choledochocele was diagnosed and the patient was referred for endoscopic treatment (▶Video 1).

The lesion was resected en bloc by hot snare papillectomy (▶Fig. 2) and the stones were also removed (▶Fig. 3). Endoscopic retrograde cholangiopancreatography was then performed and no further biliary alterations were seen. Pancreatic and biliary sphincterotomies were performed and a plastic stent was placed in the pancreatic duct to prevent further pancreatitis.

▶Fig. 1 Subepithelial swelling proximal to the major papilla.

▶Video 1 Choledochocele was diagnosed by duodenoscopy and endoscopic ultrasound. A complete en bloc resection with hot snare papillectomy was performed. At the 2-month follow-up duodenoscopy, no residual lesions were seen.

▶Fig. 2 Complete en bloc resection of the lesion by hot snare papillectomy.

▶Fig. 3 Choledochocele with stones.

▶Fig. 4 2-month follow-up duodenoscopy.
post-procedural acute pancreatitis and papillary stenosis. Two through-the-scope clips were deployed to close the mucosal defect. No post-procedural complications were observed. Pathological examination showed hyperplasia of the biliary epithelium and inflammatory infiltration without dysplasia.

At the 2-month follow-up, duodenoscopy showed no residual lesions in the ampullary area and spontaneous pancreatic stent migration (Fig. 4). In our opinion, this case confirms that endoscopic papillectomy may be a good option for the treatment of patients with choledochocele.

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Competing interests

The authors declare that they have no conflict of interest.

The authors

Vincenzo Giorgio Mirante1, Paolo Cecinato1, Simone Grillo1, Giuliana Sereni1, Matteo Lucarini1, Marina Beltrami2, Romano Sassatelli1

1 Gastroenterology and Digestive Endoscopy Unit, Azienda USL – RCCS di Reggio Emilia, Reggio Emilia, Italy
2 Medicine and Gastroenterology Unit, Azienda USL – IRCCS di Reggio Emilia, Reggio Emilia, Italy

Corresponding author

Vincenzo Giorgio Mirante, MD
Department of Oncology and Advanced Technologies, Gastroenterology and Digestive Endoscopy Unit, Azienda USL – IRCCS di Reggio Emilia, Viale Risorgimento 80, 42123 Reggio nell’Emilia, Italy
Fax: +39-0522-295941
v.mirante@libero.it

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