Endoscopic ultrasonography-guided hepaticogastrostomy with parenchymal metal stent placement

Endoscopic ultrasonography-guided hepaticogastrostomy (EUS-HGS) is performed to create a biliary drainage route for malignant distal biliary obstruction during complicated endoscopic retrograde cholangiopancreatography [1,2]. However, when EUS-HGS is performed in patients with cholangitis and ascites, metal stent placement may cause peripheral obstructive cholangitis (Fig. 1a), while plastic stents may cause biliary peritonitis due to bile leakage into the ascites (Fig. 1b) [3,4]. To address this challenge, we implemented a novel EUS-HGS method of hepatic parenchymal metal stent placement with plastic stent in the bile duct (Fig. 2), which proved to be effective (Video 1).

Our patient was a 64-year-old woman with biliary and duodenal stents for relieving the obstruction of the distal bile duct and duodenum due to unresectable pancreatic cancer. She developed cholangitis due to biliary stent dysfunction (Fig. 3). We decided to perform EUS-HGS with hepatic parenchymal metal stent placement using a laser cut-type fully covered metal stent (LFCMS) along with plastic stent placement in the bile duct.

After puncturing B3 with a 19-gauge needle using a convex ultrasound endoscope, a 0.025-inch guidewire was placed into the common bile duct, and a 6-mm balloon was used to dilate the fistula. Subsequently, the LFCMS (8 mm diameter, 8 cm length, X-Suit NIR Biliary Metallic Stent; Olympus Medical Systems, Tokyo, Japan) was deployed, with the stent end in the hepatic parenchyma slightly outside the bile duct, while being careful not to occlude the bile duct with the stent. After confirming the position of the metal stent by contrast to ensure that it was not in the bile duct, a 7-Fr plastic stent (TYPE IT;
Gadelius Medical, Tokyo, Japan) was placed in the bile duct (Fig. 4, Fig. 5). The patient’s clinical condition improved after the procedure.

The LFCMS is retained in place more easily than the braided-type metal stent. Therefore, LFCMS was considered suitable for this EUS-HGS method in a patient with cholangitis and ascites.

Endoscopy_UCTN_Code_TTT_1AS_2AD

Acknowledgement

This work was supported in part by The National Cancer Center Research and Development Fund (31-A-13) and (2021-S-5).

Competing interests

The authors declare that they have no conflict of interest.

The authors

Motohiro Yoshinari1, Susumu Hijioka¹, Takuji Okusaka¹, Yutaka Saito²
1 Department of Hepatobiliary and Pancreatic Oncology, National Cancer Center Hospital, Tokyo, Japan
2 Department of Endoscopy Division, National Cancer Center Hospital, Tokyo, Japan

Corresponding author

Susumu Hijioka, MD, PhD
Department of Hepatobiliary and Pancreatic Oncology, National Cancer Center Hospital, 5-1-1 Tsukiji, Chuo-ku, Tokyo 104-0045, Japan
shijioka@ncc.go.jp
References


Bibliography

Endoscopy 2022; 54: E719–E721
DOI 10.1055/a-1759-2479
ISSN 0013-726X
published online 7.3.2022
© 2022. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

Endoscopy E-Videos is an open 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. Processing charges apply (currently EUR 375), discounts and waivers according to HINARI are available.

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

▶ Fig. 5 Plastic stent placement in the bile duct. a Fluoroscopic image: a plastic stent was placed in the bile duct. b Endoscopic image after stent placement. c Three-dimensional reconstruction.