A novel case of biliary common bile duct reconstruction by the rendezvous technique using endoscopic cholangioscopy and percutaneous cholangioscopy

Biliary tract injuries during cholecystectomy are a rare, but not exceptional, adverse event, with severe consequences. The Strasberg classification with Bismuth modification is most frequently used to classify biliary tract injuries [1, 2]. Expertise in endoscopic, radiologic, and surgical management is required, especially for major biliary tract injuries [3]. A transhepatic-endoscopic approach is useful in difficult cases [4, 5]. We aim to describe a new solution after failure of the standard rendezvous technique, namely double cholangioscopy rendezvous.

A 21-year-old woman developed jaundice 3 months after she underwent cholecystectomy for lithiasis. The patient was referred to our center after undergoing an initial endoscopic retrograde cholangiopancreatography (ERCP), which was unsuccessful because of a blockage below the hilum (Strasberg–Bismuth E2) (Fig. 1). A repeat ERCP attempt also resulted in failure, and external percutaneous drainage was required, with an 8.5-Fr drain placed. The patient’s jaundice subsequently decreased.

A joint decision was made by the gastroenterologists and surgeons to perform the rendezvous technique to avoid a hepatojejunostomy with a high risk of secondary stricture because of its proximity to the convergence. The first attempt made at this procedure was unsuccessful, and the 8.5-Fr percutaneous drain was replaced with a 12-Fr drain (Fig. 2a). A second attempt using simultaneous percutaneous cholangioscopy and ERCP was scheduled for a few days later (Video 1), but this repeat classical rendezvous technique was a fail-
ure too. Attempts guided with cholangioscopy by the endoscopic route were also unsuccessful. Cholangioscopy was used for ERCP to visualize the stricture, while percutaneous cholangioscopy was performed with a bronchoscope. A needle was used with the bronchoscope to puncture the stricture, and the common bile duct was found with a guidewire. The guidewire was then recovered by the ERCP approach, and a percutaneous internal/external drain (12 Fr) was inserted. A few weeks later, the percutaneous internal/external drain was exchanged with three 12-Fr plastic stents (▶ Fig. 2b), which were replaced every 4 months for a duration of 1 year.

Endoscopy_UCTN_Code_TTT_1AR_2AG

Competing interests

The authors declare that they have no conflict of interest.

The authors

Jean-Philippe Ratone1, Fabrice Caillol1, Mariola Marx1, Solene Hoibian1, Yanis Dahel1, Marc Giovannini1, Jacques Devière2
1 Endoscopy Unit, Paoli-Calmettes Institute, 232 Boulevard de Sainte Marguerite, 13009 Marseille, France
jperratone@hotmail.fr

References


Corresponding author

Jean-Philippe Ratone, MD
Endoscopy Unit, Paoli-Calmettes Institute, 232 Boulevard de Sainte Marguerite, 13009 Marseille, France
jperratone@hotmail.fr

Bibliography

Endoscopy
DOI 10.1055/a-1883-9446
ISSN 0013-726X
published online 2022
© 2022. The Author(s).
This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

Endoscopy E-Videos
https://eref.thieme.de/e-videos

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 acc. to HINARI are available.

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