Biliary strictures are frequently encountered in interventional endoscopy. Their etiological diagnosis may be complicated [1]. Endoscopic ultrasound (EUS) guided biopsies, brush cytology, and wire-guided biopsies allow a diagnosis in most cases. Single-operator cholangioscopy (SOC) has radically changed the diagnostic approach, allowing visualization of the lesion, endoscopic characterization, and targeted biopsies [2].

We report the case of a 71-year-old woman with a history of endometrial adenocarcinoma, with muscular and bone recurrence 4 years after treatment. She developed a sudden jaundice without any other clinical signs. A magnetic resonance cholangiopancreatography found a circumferential parietal thickening of the main bile duct with dilatation of the intrahepatic bile ducts (Fig.1). We decided to perform an EUS, which showed extensive cholangitis in the middle part of the bile duct with circumferential thickening of the bile duct mucosa. A 22 G needle biopsy was performed. Endoscopic retrograde cholangiopancreatography (ERCP) was then performed (Video 1) with SOC, which showed that the strictured area was indeed a fibrous stenosis with anarchic vascularization.

Biopsies were taken with forceps. Brush cytology and wire-guided biopsies were also performed. The procedure was completed with the placement of three plastic stents (one 15 cm and 8.5 Fr stent in the left bile duct; one 12 cm and 8.5 Fr stent and one 12 cm and 7 Fr stent in the right intrahepatic bile ducts). Histological examination found carcinomatous cells (mutated p53, PAX8 +), which were presumed to be metastasis of gynecological origin (Fig.3).

The use of SOC allows a finer analysis of indeterminate biliary stenosis. The presence of aberrant vascularization seems to be correlated with the neoplastic nature of the lesion [3]. SOC therefore allows macroscopic analysis of the lesion and targeted biopsies, probably making biliary sampling less random [4, 5].

Acknowledgement

This work was supported by French state funds managed within the “Plan Investissements d’Avenir” and by the ANR (reference ANR-10-IAHU-02).
The authors declare that they have no conflict of interest.

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Funding

Agence Nationale de la Recherche
ANR-10-IAHU-02

Competing interests

The authors declare that they have no conflict of interest.
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Endoscopy
DOI 10.1055/a-1884-9055
ISSN 0013-726X
published online 2022
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Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany