Post-cholecystectomy biliary leakage mimicking a neoplastic lesion: contribution of cholangioscopy in diagnosis and endoscopic treatment

We report the case of a 70-year-old woman with no relevant medical history, who was referred to our department for jaundice and liver dysfunction 1 month after cholecystectomy (Fig. 1). Contrast-enhanced computed tomography of the abdomen and the pelvis showed dilatation of the intrahepatic bile ducts, upstream of the biliary convergence, with an infiltration of the hepatic hilum. Magnetic resonance imaging confirmed the presence of biliary stenosis at the level of the convergence, together with circumferential thickening of the wall of the upper part of the main bile duct, extending over 2 cm (Fig. 2).

We performed endoscopic ultrasound, which revealed a hypoechoic area at the level of the biliary convergence, with intraluminal hyperechoic material, mimicking stones. Then, we performed endoscopic retrograde cholangiopancreatography (ERCP), which did not result in satisfactory opacification of the biliary tract (Fig. 3). After endoscopic sphincterotomy, we used a single-operator cholangioscope (SOC) to characterize the biliary damage (Video 1). A stone located in the upper part of the main bile duct was extracted. Then, SOC revealed a lateral wound of the main bile duct, complicated by a bilioma, within which a surgical clip was found. Stenosis of the common bile duct was associated with this biliary leakage. A guidewire was placed under SOC control and a 10F, 12-cm plastic biliary stent was placed (Fig. 4) [1, 2, 3].

The patient’s post-endoscopic course was rapidly favorable. Three months later, a new ERCP was performed to remove the prosthesis and to confirm healing of the biliary wound, with persistence of the biliary leak. A new ERCP was then performed to remove the prosthesis and to confirm healing of the biliary wound. The patient’s post-endoscopic course was rapidly favorable.
of stenosis. A balloon dilatation was performed, followed by insertion of two 8.5F, 12-cm plastic stents for calibration (▶Fig. 5) [4].

We illustrate here the use of SOC, as a combined diagnostic and therapeutic means, when the imaging potentially suggested malignancy. Thus, SOC must be democratized in management of complex biliary duct pathology.

Conflict of Interest

The authors declare that they have no conflict of interest.

References


Key words

Strictures, Cholangioscopy, Pancreatobiliary (ERCP/PTCD), Diagnostic ERC, Tissue diagnosis, ERC topics