An 84-year-old woman was admitted for cholangitis. Her leukocyte count was 14.76 Gpt/L (normal range 4.0–10.0 Gpt/L), total bilirubin was 67 mmol (normal < 17 mmol), alkaline phosphatase was 6.48 mmol (normal range 0.58–1.74 mmol) and γ-glutamyltransferase was 7.04 (normal range 0.1–0.7). The past medical history was remarkable for a cholecystectomy and a choledochoduodenostomy carried out 21 and 15 years ago, respectively. An abdominal ultrasound carried out after admission to the referring hospital showed dilation of the common bile duct (CBD) and choledocholithiasis. Therapy with tazobactam/piperacillin and metronidazole was started. Endoscopic retrograde cholangiopancreatography (ERCP) was carried out twice at the same hospital but failed both times, and the patient was referred to our medical center.

We carried out another ERCP, which disclosed an opening in the duodenal bulb (Fig. 1) and an intact ampulla of Vater. Cholangiography revealed multiple filling defects in the distal CBD and contrast extravasation into the stomach via the duodenal orifice (choledochoduodenostomy) (Fig. 2). Deep cannulation of the intrahepatic bile ducts was accomplished after passing a guide wire (Fig. 2). The intrahepatic biliary tree could only be visualized on occlusion cholangiography with the balloon inflated above the choledochoduodenostomy (Fig. 3). A sphincterotomy was carried out with subsequent extraction of multiple stones and a large amount of sludge (Fig. 4). The patient recovered and on follow-up 6 months later, she is doing well.

The “sump syndrome” is rarely seen in the present time. This syndrome is a complication of a choledochoenterostomy and results from the accumulation of debris, which enters into the CBD from the duodenum [1,2]. Often, the debris cannot escape distally through the intact ampulla of Vater and starts accumulating within the distal, nonfunctioning CBD, resulting in the creation of a “sump”. The debris induces the formation of sludge and stones, which can occlude the entire CBD. Clinically, patients present with recurrent attacks of abdominal pain or cholangitis [2,3]. The sump syndrome can be treated surgically by creating a Roux-en-Y hepaticojejunostomy and by endoscopy by performing a biliary sphincterotomy and extracting the debris from the CBD [2,3].

Cholangitis as a late complication of choledochoduodenostomy: the sump syndrome

M. Venerito1, L. C. Fry1, S. Rickes2, P. Malferttheiner1, K. Mönkemüller1
1 Division of Gastroenterology, Hepatology and Infectious Diseases, Universitätsklinikum Magdeburg, Otto-von-Guericke University, Magdeburg, Germany
2 St Salvador Krankenhaus, Halberstadt, Germany

Endoscopy_UCTN_Code_CCL_1AZ_2AK
References

Bibliography
Endoscopy 2009; 41: E142 – E143
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author
K. Mönkemüller, MD, PhD, FASGE
Division of Gastroenterology, Hepatology and Infectious Diseases
Universitätsklinikum Magdeburg
Otto-von-Guericke University
Leipziger Straße 44
39120 Magdeburg
Germany
Fax: +49-391-6713105
klaus.moenkemueller@med.ovgu.de

Venerito M et al. The sump syndrome... Endoscopy 2009; 41: E142–E143