Pancreatic duct strictures may be due to acute or chronic pancreatitis, pancreatic neoplasms, or anastomotic stenosis. Some of these strictures may be almost complete and only traversable with hydrophilic guide wires. When the passage of tapered catheters, Soehendra or balloon dilators is not possible, appropriate endoscopic drainage of the pancreatic duct may fail. Blind passage of a needle knife [1] or endoscopic ultrasound (EUS)-guided antegrade drainage may be helpful [2–4].

The Cremer cystogastrostome was particularly developed for transmural cystgastrostomy or cystoduodenostomy, and has been recently used for transmural biliary and pancreatic EUS-guided drainage [4,5]. The 6-Fr diameter version, with cutting current settings, is known for its high traversability, even through hard tissue. We describe the successful use of the 6-Fr cystogastrostome (EndoFlex, Boucart Medical, Brussels, Belgium) in two patients with extremely tight pancreatic strictures. The first patient was 53 years of age and had chronic pancreatitis with a severe stricture of the main pancreatic duct (MPD), measuring 15 mm in length. After several failed attempts to pass the stenosis using a variety of catheters, recanalization was finally carried out using the 6-Fr cystostome on a 0.035 Jagwire (Boston Scientific Benelux, Diegem, Belgium), with pure cutting current (effect 4, 40 W, Vio300D, Erbe Belgium, Diegem, Belgium). This was followed by successful stenting with a plastic 7-Fr stent (Cook, Limerick, Ireland) (Fig. 1). In the second case, we used the cystostome via an anterograde approach after endoscopic retrograde pancreatography (ERCP) to access the pancreatic duct failed due to a complete block of the lumen within the head of the pancreas. EUS-guided, 19-gauge puncture of the pancreatic duct allowed positioning of a 0.035 Jagwire through the stricture in the duodenum. After numerous attempts to pass tapered catheters failed, deep MPD cannulation was achieved using the cystogastrostome with cutting current. Balloon dilation (Hurricane RX, Boston Scientific, Diegem, Belgium) and stenting with a plastic 7-Fr ZPSOF (Cook, Limerick, Ireland) (Fig. 1). In the second case, we used the cystostome via an anterograde approach after endoscopic retrograde pancreatography (ERCP) to access the pancreatic duct failed due to a complete block of the lumen within the head of the pancreas. EUS-guided, 19-gauge puncture of the pancreatic duct allowed positioning of a 0.035 Jagwire through the stricture in the duodenum. After numerous attempts to pass tapered catheters failed, deep MPD cannulation was achieved using the cystogastrostome with cutting current. Balloon dilation (Hurricane RX, Boston Scientific, Diegem, Belgium) and stenting with a plastic 7-Fr ZPSOF (Cook, Limerick, Ireland) (Fig. 1). In the second case, we used the cystostome via an anterograde approach after endoscopic retrograde pancreatography (ERCP) to access the pancreatic duct failed due to a complete block of the lumen within the head of the pancreas. EUS-guided, 19-gauge puncture of the pancreatic duct allowed positioning of a 0.035 Jagwire through the stricture in the duodenum. After numerous attempts to pass tapered catheters failed, deep MPD cannulation was achieved using the cystogastrostome with cutting current. Balloon dilation (Hurricane RX, Boston Scientific, Diegem, Belgium) and stenting with a plastic 7-Fr ZPSOF (Cook, Limerick, Ireland) (Fig. 1).
complications or evidence of post-procedural pain in these cases.

In conclusion, the cystogastrostome, with pure cutting current, allows adequate endoscopic drainage, including dilation and stent placement, and can be safely used in those pancreatic and biliary strictures that are not traversable with conventional methods.

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E. Kim, T. Aouattah, P. H. Deprez
Department of Gastroenterology, Cliniques Universitaires St-Luc, Université Catholique de Louvain, Brussels, Belgium

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Corresponding author
P. H. Deprez
Gastroenterology Department Cliniques Universitaires St-Luc Université Catholique de Louvain (UCL) Avenue Hippocrate 10 1200 Brussels Belgium Fax: +32-2-7648927 pierrehenri.deprez@uclouvain.be