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 cystogastrostomy 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 Zimmon 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 stent were thereafter carried out successfully (Fig. 2). We have used a similar cystostome approach in various biliary and pancreatic strictures in another three patients, including a patient with a tight hilar biliary stricture following right hepatectomy. There were no
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.

Competing interests: None

References

Bibliography
Endoscopy 2011; 43: E340 – E341
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

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