Endoscopic ultrasound-guided retrograde pancreatic stent placement for the treatment of stenotic jejuno-pancreatic anastomosis after a Whipple procedure

A 50-year-old man, who had been suffering from repetitive pancreatitis for 1 year due to stenosis at the jejuno-pancreatic anastomosis after pancreatoduodenectomy (Fig. 1a), underwent EUS-guided retrograde pancreatic duct stenting. Prior to the procedure, despite careful searching with a forward-viewing scope, the orifice of the pancreatic duct could not be detected due to severe luminal inflammation. A convex-type EUS scope (GF-UCT240; Olympus, Tokyo, Japan) was advanced to the anastomotic site (Fig. 1b) and, using color Doppler, the puncture line was adjusted to avoid blood vessels. A 19-gauge needle (SonoTip Pro Control; Medi-globe, Achenmühle, Germany) was inserted into the main pancreatic duct (Fig. 1c), and advancement of a guide wire (VisiGlide, 0.025-inch; Olympus) fully into the duct was confirmed using contrast medium (Fig. 1d). Dilatation was unsuccessful with a bougie catheter (Soehendra, 4–7Fr; Cook Medical, Winston-Salem, North Carolina, USA), but was easily completed using a diathermic sheath (Cysto-Gastro Set, 6Fr; Endo-Flex, Voerde, Germany) [4]. A plastic stent (Geenen, 5Fr; Cook Medical) was placed (Fig. 1e) and the patient’s symptoms disappeared immediately.

Two months later, as scheduled, the stent was upsized to a 7Fr with balloon dilation (Quantum TTC, 6mm; Cook Medical) (Fig. 2a). No complications occurred during these procedures and the patient was subsequently healthy (Fig. 2b).

Endoscopic ultrasound (EUS)-guided [1, 2] or percutaneous [3] rendezvous methods have been used for the treatment of stenosis at the jejuno-pancreatic anastomosis following pancreatoduodenectomy. However, the use of EUS-guided retrograde pancreatic duct stenting has not been reported, even though it may be preferable from the point of view of complications.

Compared with the rendezvous method, the retrograde procedure presented here is a one-step, one-scope method that is
not performed through the abdominal cavity; hence, it carries a lower risk of pancreatic juice leakage and other complications [5]. This method is worthwhile when attempting to rescue a stenotic pancreatojejunostomy after a Whipple resection.

Competing interests: None

References


Bibliography

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Corresponding author
Hiroyuki Matsubayashi, MD, PhD
Division of Endoscopy
1007 Shimonagakubo
Nagaizumi, Shizuoka 411-8777
Japan
Fax: +81-55-9895692
h.matsubayashi@scchr.jp