Massive hemobilia following transpapillary bile duct biopsy treated by using a covered self-expandable metal stent

Severe hemobilia after a forceps biopsy is very rare [1,2]. The management of uncontrolled hemobilia after endoscopic procedures includes percutaneous radiologic intervention or surgery [3,4]. Recently, successful endoscopic hemostasis using covered self-expandable metal stents (CSEMS) for uncontrolled bleeding following sphincterotomy, stent removal, or papillary balloon dilation has been reported [3–5]. We report a case of massive hemobilia after a transpapillary forceps biopsy of the bile duct and successful endoscopic hemostasis with placement of a CSEMS.

A 51-year-old woman was admitted because of abdominal pain and jaundice. Abdominal CT showed cancer of the pancreatic head with a stricture of the common bile duct (CBD). Cholangiogram showed dilatation of the proximal bile duct with abrupt luminal narrowing of the CBD (Fig. 1a). After endoscopic biliary sphincterotomy, transpapillary forceps biopsy was performed. A rat-tooth biopsy forceps (FB-39Q-1, Olympus, Tokyo, Japan) was used for tissue sampling at the constricted segment of the CBD (Fig. 1b), but massive hemobilia occurred immediately afterwards (Fig. 2, Video 1). To control the hemobilia, balloon tamponade with a controlled radial expansion balloon (Boston Scientific, Natick, MA, USA; 10 mm, 8 atm, 60 seconds) was attempted three times (Fig. 3a). As the uncontrolled hemobilia continued, a partially covered SEMS (10 mm diameter, 8 cm long; Bonastent, Standard Sci-Tech, Seoul, Korea) was inserted to achieve hemostasis through compression exerted by the expandable stent (Fig. 3b). Once the CSEMS had been placed, the hemobilia decreased and then stopped. The patient’s hemodynamic profile and vital signs were stable, and there was no further bleeding.

Complications related to transpapillary forceps biopsies are infrequent; usually, iatrogenic hemobilia is minor and can be controlled with conservative treatment [1]. Uncontrolled massive hemobilia after a transpapillary forceps biopsy has not previously been reported. Recently, placement of a CSEMS has been introduced as an effective means of endoscopic hemostasis for bleeding that could not be controlled with conventional methods [3–5]. If massive bleeding from the bile duct occurs during endoscopic retrograde cholangiopancreatography, hemostasis can be achieved promptly using a CSEMS, without radiological intervention or surgery. Endoscopic treatment using a CSEMS could be a useful way of providing effective hemostasis in selected patients with uncontrolled hemobilia of the extrahepatic bile duct.

Endoscopy_UCTN_Code_TTT_1AR_2AD

Competing interests: None
References

1 Jailwala J, Fogel EL, Sherman S et al. Triple-
tissue sampling at ERCP in malignant biliary
obstruction. Gastrointest Endosc 2000; 51:
383–390

2 Ikeda M, Maetani I, Terada K et al. Usefulness
of endoscopic retrograde biliary biopsy
using large-capacity forceps for extrahepat-
ic biliary strictures: a prospective random-
ized study. Endoscopy 2010; 42: 837–841

3 Itoi T, Yasuda I, Doi S et al. Endoscopic hemo-
statics using covered metallic stent place-
ment for uncontrolled post-endoscopic
sphincterotomy bleeding. Endoscopy 2011;
43: 369–372

4 Volats JC, Funakoshi N, Bauret P et al. Cov-
ered self-expandable biliary stents for the
treatment of bleeding after ERCP. Gastro-
intest Endosc 2013; 78: 183–187

5 Aslinia F, Hawkins L, Darwin P et al. Temporo-
ral placement of a fully covered metal stent
to tamponade bleeding from endoscopic
papillary balloon dilation. Gastrointest End-
cosc 2012; 76: 911–913

Bibliography

DOI http://dx.doi.org/
Endoscopy 2014; 46: E161–E162
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Jong Ho Moon, MD, PhD
SoonChunHyang University School of Medicine
Digestive Disease Center
SoonChunHyang University Bucheon Hospital
170 Jomaru-ro, Wonmi-gu
Bucheon 420-767
Korea
Fax: +82-32-6215080
jhmoon@schmc.ac.kr