Successful endoscopic dilation of severe bilioenteric strictures with a wire-guided diathermic dilator and short-type single-balloon enteroscope

Recently, balloon enteroscopy has made possible the use of endoscopic approaches to the surgically reconstructed intestine [1–4], so that hepaticojejunostomy strictures can be treated endoscopically. We describe the successful endoscopic dilation of a severe hepaticojejunostomy stricture with a wire-guided diathermic dilator (6-Fr, 180-cm Cysto-Gastro-Set; Endo-flex, Voerde, Germany) (Fig. 1). A 66-year-old woman underwent pylorus-preserving pancreaticoduodenectomy for cancer of the pancreatic head. Cholangitis due to bilioenteric stricture developed at the third month after surgery. A short-type, single-balloon enteroscope (SIF-Y0004V01; Olympus Medical Systems, Tokyo, Japan) was used to perform balloon enteroscope-assisted endoscopic retrograde cholangiopancreatography (ERCP). A 0.025-inch guidewire could pass through the stricture, but an ERCP imaging catheter could be passed through the stricture. The anastomosis was dilated with a 6.8-Fr Quantum TTC Biliary Balloon Dilator (6-Fr Cysto-Gastro-Set), with a working length of 180 cm and a maximum diameter of 2.0 mm, which can be used to dilate severe hepaticojejunostomy strictures. A guidewire was placed in a hepatic duct, and the anastomotic stricture was electrically dilated with a 6-Fr Cysto-Gastro-Set. After the dilation procedure, an imaging catheter could be passed through the stricture. The anastomosis was dilated with a 6.8-Fr Quantum TTC Biliary Balloon Dilator 6 mm in diameter (QBD-6X3; Cook Medical), after which the cholangitis decreased (Video 1). There were no adverse events. The stricture was classified as a type A1 stricture according to the classification of Mönkemüller & Jovanovic [4]. In patients who undergo balloon enteroscopy-assisted ERCP for hepaticojejunostomy strictures, a tangential approach to the stricture site is often used. When a needle-knife is used, it is difficult to perform coaxial dilation from a tangential approach (Fig. 2b); this technique has caused anastomotic perforation [5] and so is not considered optimal. We therefore use a 6-Fr Cysto-Gastro-Set for the endoscopic dilation of anastomotic strictures (Fig. 2a), which facilitates dilation along the same axis as the guidewire [5]. Our results suggest that a 6-Fr wire-guided diathermic dilator may be useful for anastomotic dilation in patients with severe hepaticojejunostomy strictures.

Endoscopy_UCTN_Code_TTT_1AR_2AG

Competing interests: None

References

1 Yamachi H, Kida M, Okuwa K et al. Short-type single balloon enteroscope for endoscopic retrograde cholangiopancreatography with altered gastrointestinal anatomy. World J Gastroenterol 2013; 19: 1728–1735
Kawakami H, Kuwatani M, Kawakubo K et al. Transpapillary dilation of refractory severe biliary stricture or main pancreatic duct by using a wire-guided diathermic dilator (with video). Gastrointest Endosc 2014; 79: 338–343.

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1391240
Endoscopy 2015; 47: E94–E95
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Hiroshi Yamauchi, MD
Department of Gastroenterology
Kitasato University East Hospital
2-1-1 Asamizodai, Minami-ku, Sagamihara
Kanagawa 252-0380
Japan
Fax: +81-42-749-8690
yhiroshi@kitasato-u.ac.jp