Salvage endoscopic ultrasound–radiologic rendezvous to re-establish biliary flow following duodenectomy with ablation of papilla

A 54-year-old woman underwent curative duodenectomy with duodenojejunal anastomosis for adenocarcinoma. The day after the procedure she developed jaundice. The computed tomography (CT) scan showed a staple line on the lower part of the common bile duct (CBD) with biliary tree dilatation (● Fig. 1) and a normal pancreatic duct. Under endoscopic ultrasound (EUS) control a transbulbar cholangiography was performed on the lower part of the CBD, confirming biliary dilatation without any leakage of contrast medium into the duodenum because of complete transection of the papilla after duodenectomy with duodenojejunal anastomosis.

Video 1

Endoscopic ultrasound (EUS)-guided cholangiography showing dilatation of the common bile duct without any passage into the duodenum because of complete transection of the papilla after curative duodenectomy with duodenojejunal anastomosis.

Video 2

Fistulotomy on guidewire allowing a communication between the duodenum and the common bile duct (CBD) to be created. The wall of the lower CBD can be seen.

Fig. 1  a, b Staple line on the common bile duct (arrow) with dilatation of the biliary tree and a normal pancreatic duct in a 54-year-old patient after curative duodenectomy with duodenojejunal anastomosis for adenocarcinoma.

Fig. 2 Looping of the guidewire in the cystic stump.

Fig. 3 Passage of the guidewire by percutaneous transhepatic cholangiography, through the common bile duct and into the duodenum via the bilioduodenal access previously created under endoscopic ultrasound (EUS).

Fig. 4 Fully covered metal and plastic stents in place, restoring the biliary flow.
duodenostomy has been described using a lumen-apposing FCSEMS after failed ERCP [2]. Perez-Miranda et al. reported successful repair, by EUS-guided choledochoduodenostomy and magnets, of a disconnected CBD following orthotopic liver transplantation [3].

In this particular case we did not use a lumen-apposing SEMS; this was to avoid sump syndrome and malfunction once the CBD was empty. We decided to perform a EUS–radiologic rendezvous [4, 5] in order to deliver the FCSEMS in a position that more nearly replicated the normal anatomy to prevent possible later adverse events. In conclusion, interventional EUS is the key technique with which to access the biliary tree in cases of altered anatomy and EUS–radiologic rendezvous helps in difficult situations, sparing the need for major surgery with its related morbidity and mortality.

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