Percutaneous transhepatic biliary drainage-assisted, endoscopic ultrasound-guided hepaticoduodenostomy for isolated complete right intrahepatic duct obstruction

Endoscopic ultrasound (EUS)-guided biliary drainage has emerged as an alternative modality for an obstructed intrahepatic duct (IHD). However, isolated right IHD obstruction has not been considered suitable for EUS-guided intervention because the right IHD may not be immediately adjacent to the duodenal wall or because the portal vein could be close to the route of approach [1]. We report our experience of percutaneous transhepatic biliary drainage (PTBD)-assisted, EUS-guided hepaticoduodenostomy for isolated complete right IHD obstruction.

A 43-year-old woman presented with epigastric pain and cholestatic liver dysfunction after open cholecystectomy. Magnetic resonance cholangiopancreatography (MRCP) showed an abrupt cut-off of the right anterior segmental bile duct, suggesting a transection injury following the cholecystectomy. When a transection injury has occurred, surgical reconstruction with biliary enteric anastomosis is indicated [2, 3]. PTBD was initially performed for biliary decompression. As the remaining bile duct was too short to be connected to the jejunum, the surgeon suggested segmental liver resection instead of hepaticojejunostomy; however, the patient refused surgical management, so we performed EUS-guided drainage with the assistance of PTBD.

An echoendoscope was positioned close to the blind end of the transected bile duct, with the PTBD catheter being used as the target. An EUS-guided puncture (19-gauge needle; Boston Scientific) was performed into the blind end of bile duct, which was confirmed by contrast injection. A 0.025-inch hydrophilic guidewire (Fig. 1; Video 1); a needle knife and 4-mm balloon catheter were then used for tract dilation. A fully covered self-expanding metal stent (6 mm in diameter, 7 cm in length; M.I. Tech, Seoul) was introduced and positioned in the right anterior IHD. A new anastomosis between the transected IHD and the duodenum was therefore successfully created. The PTBD catheter was removed 3 days later after it had been confirmed that the stent was functioning well (Fig. 2; Video 1).

The metal stent was removed 11 months later. A retrograde cholangiogram through the fistula tract 6 months after removal of the stent showing that the hepaticoduodenostomy tract had remained patent (Fig. 3; Video 1).

Competing interests: None

Min Keun Cho1, Hoonsub So1, Kyoungwon Jung1, Jae Hoon Lee2, Do Hyun Park1

1 Department of Internal Medicine, University of Ulsan College of Medicine, Asan Medical Center, Seoul, South Korea
2 The Division of Hepatobiliary and Pancreatic Surgery, Department of Surgery, University of Ulsan College of Medicine, Asan Medical Center, Seoul, South Korea
References


Bibliography

DOI http://dx.doi.org/10.1055/s-0042-117223
Endoscopy 2016; 48: E317 – E318
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
Do Hyun Park, MD, PhD
Department of Internal Medicine
University of Ulsan College of Medicine
Asan Medical Center
88 Olympic-ro 43-gil, Songpa-gu
Seoul 05505
South Korea
Fax: +82-2-4760824
dhpark@amc.seoul.kr