Endosonographically guided gallbladder drainage to treat neoplastic jaundice after Roux-en-Y gastric resection

A 81-year-old man, who had undergone subtotal gastric resection with Roux-en-Y anastomosis for gastric adenocarcinoma 2 years earlier, was admitted to our hospital for obstructive jaundice. Abdominal computed tomography showed a solid mass (30 × 30 mm) at the pancreatic head, involving the common bile duct and the duodenum and suspicious for portal vein and mesenteric axis invasion (Fig. 1). An endoscopic ultrasonography (EUS)-guided fine needle aspiration was performed and a diagnosis of metastasis of gastric adenocarcinoma was made.

Considering the post-surgical anatomy, and in order to obtain endoscopic biliary drainage, a transgastric intrahepatic EUS-guided approach was attempted. A linear echoendoscope (GF-UCT140; Olympus, Tokyo, Japan) was used but the intrahepatic bile ducts were not dilated enough to access them. However the hydropic gallbladder was clearly visible from the jejunal route. EUS-guided transluminal gallbladder drainage was therefore performed using a lumen-apposing metal stent (LAMS) (Hot Axios; Boston Scientific, Natick, Massachusetts, USA) with a lumen diameter of 10 mm. The gallbladder was first punctured using a 19G access needle (EchoTip Ultra; Cook Medical, Limerick, Ireland) and a 0.035-inch guidewire (VisiGlide; Olympus) was left inside to stabilize the echoendoscope position. Subsequently the stent was introduced into the gallbladder lumen using its cautery tip. Finally the stent was deployed (Fig. 2), with subsequent rapid drainage of the gallbladder into the jejunal lumen (Fig. 3, and Video 1), and nasobiliary drainage was inserted through the stent into the lumen of the gallbladder (Fig. 4). The procedure was successful and the patient’s jaundice rapidly resolved; after 2 weeks total bilirubin had fallen from 11.3 g/dL to 2.5 g/dL.)
EUS-guided gallbladder drainage using LAMS is safe and effective in the treatment of acute cholecystitis in high surgical risk candidates [1, 2]. Our case shows the feasibility of this technique also for obtaining palliative biliary endoscopic drainage when other routes are precluded.

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Competing interests

None

The Authors

Paolo Cecinato, Maurizio Cavina, Giuliana Sereni, Francesco Decembrino, Veronica Iori, Cristiana Tioli, Romano Sassatelli
Unit of Gastroenterology and Digestive Endoscopy, Arcispedale Santa Maria Nuova-IRCCS, Reggio Emilia, Italy

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