



Figure 1 A self-expanding metal stent (SEMS) has been placed using a rendezvous endoscopic retrograde cholangiopancreatography procedure. It should be noted that the duodenal end of the SEMS is distal to the normal opening of the bile duct.

In a 60-year-old man with inoperable adenocarcinoma of the pancreatic head, endoscopic retrograde cholangiopancreatography (ERCP) was attempted in order to place a biliary self-expanding metal stent (SEMS) across the stricture in the bile duct. However, all attempts to gain access to the bile duct failed. It was then decided to perform a rendezvous-procedure ERCP.

After percutaneous transhepatic puncture of the bile duct under ultrasound guidance, a guide wire was positioned in the common bile duct, but despite several attempts it was not possible to traverse the stricture with it. The duodenoscope was then placed in the duodenum facing the papilla. Under endoscopic and fluoroscopic guidance, the multipurpose catheter was abutted against the wall of the common bile duct near the lower end, close to the papilla. The impression made by the multipurpose catheter was visible endoscopically in the duodenum as an indentation, distal to but close to the papilla. After this, a zebra guide wire was passed through the multipurpose catheter, and with the multipurpose catheter still abutting the bile duct wall, the guide wire was forced to pierce the common



Figure 2 The radiographic appearance. There is free flow of the contrast that has been injected through the percutaneous transhepatic biliary drainage catheter.

bile duct and the duodenal wall. It was then grasped with a polypectomy snare and taken out through the biopsy channel of the duodenoscope. A sphincterotome was then passed over the guide wire into the bile duct. It was then removed, and a 6-cm covered biliary SEMS (Boston Scientific, Watertown, Massachusetts, USA) was placed in the bile duct (Figure 1). Free flow of bile was seen. The percutaneous intrahepatic tract was dilated to 12 Fr, and a 12-Fr suprapubic drainage catheter was positioned above the proximal end of the SEMS (Figure 2). The percutaneous transhepatic biliary catheter was later removed and the patient was discharged from hospital.

Placement of SEMS is an established modality for palliative treatment in patients with biliary obstruction due to inoperable cancers [1,2]. Access to the bile duct is sometimes not possible during ERCP, and in these cases a combined radiographic

and endoscopic procedure may be attempted [3,4].

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References

- Conio M, Demarquay JF, Luca L et al. Endoscopic treatment of pancreatico-biliary malignancies. *Crit Rev Oncol Hematol* 2001; 37: 127–135
- Miyayama S, Matsui O, Akakura Y et al. Efficacy of covered metallic stents in the treatment of unresectable malignant biliary obstruction. *Cardiovasc Intervent Radiol* 2004; 27: 349–354
- Robertson DA, Ayres R, Hacking CN et al. Experience with a combined percutaneous and endoscopic approach to stent insertion in malignant obstructive jaundice. *Lancet* 1987; ii: 1449–1452
- Lai R, Freeman ML. Endoscopic ultrasound-guided bile duct access for rendezvous ERCP drainage in the setting of intradiverticular papilla. *Endoscopy* 2005; 37: 484–489

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