

Endoscopic ultrasound-guided pancreaticogastrostomy reconstruction

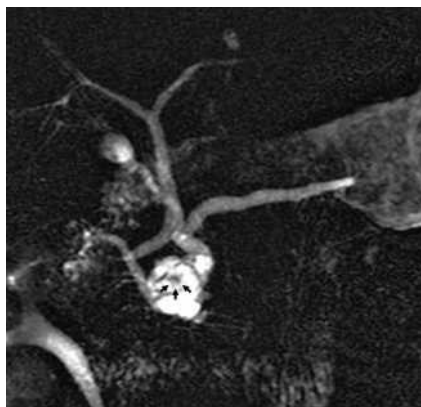


Figure 1 Magnetic resonance cholangiopancreatographic view showing the dilated branch of the pancreatic duct and a mural nodule in the dilated duct (arrow).

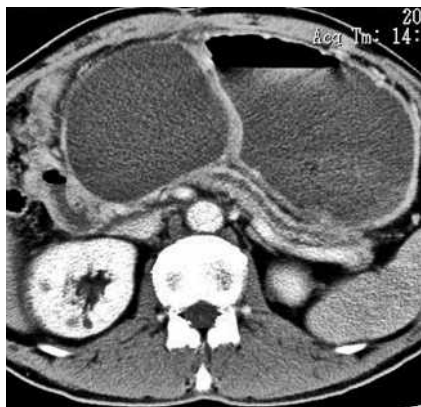


Figure 2 Computed tomographic view showing a pancreatic pseudocyst that developed 3 months after the surgical resection and pancreaticogastrostomy.



Figure 3 Computed tomographic view, showing the dilated main pancreatic duct 6 months after drainage of the pancreatic pseudocyst.



Figure 4 Fluoroscopic image showing a guide wire in the dilated duct, complete obstruction of proximal duct, outflow of the contrast through the cystogastrostomy stent, and placement of a guide wire into the distal pancreatic duct. The arrows show the previous drainage stent of the pancreatic pseudocyst.

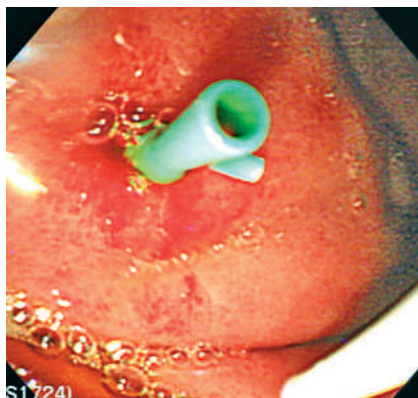


Figure 5 Endoscopic view of the stent inserted into the pancreatic duct.



Figure 6 Fluoroscopic image showing placement of the stent through the gastropancreatic fistula (arrows). The tip of the stent was positioned in the proximal duct.

Severe stenosis and obstruction of a pancreaticogastrostomy anastomosis sometimes occurs after surgical pancreatic re-

section and pancreaticogastrostomy, resulting in abdominal pain and aggravation of diabetes as a result of ductal hypertension [1]. Endoscopic ultrasound-(EUS-)guided pancreaticogastrostomy has been reported as a method for reducing ductal hypertension in patients with chronic pancreatitis. We report a patient who underwent EUS-guided reconstruction of a pancreaticogastrostomy with gastropancreatic stent placement, which rapidly improved his symptoms [2,3]. A 65-year-old man who had a branch duct type of intrapapillary mucinous neoplasm (IPMN) (● **Figure 1**) underwent a duodenum-preserving pancreatic head resection and pancreaticogastrostomy anastomosis. Forty-five days later, he developed a pancreatic pseudocyst (● **Figure 2**), which was drained under EUS guidance. Although computed tomography 6 months later showed that the pseudocyst had disappeared, the scan showed dilatation of the main pancreatic duct (● **Figure 3**). Decompression of the pancreatic duct was required to relieve his abdominal pain and reduce his hyperglycemia. Because the main pancreatic duct could not be drained by endoscopic retrograde pancreatography, EUS-guided pancreaticogastrostomy reconstruction was performed. An echo endoscope (GF-UC240 P-AL5; Olympus, Tokyo, Japan) was introduced into the stomach, and a 19-gauge needle (Echo-Tip; Wilson-Cook, Winston-Salem, North Carolina, USA) was used to puncture the main pancreatic duct and create a gastropancreatic fistula. We initially attempted to pass a 0.035-inch guide wire (Microvasive Endoscopy, Boston Scientific Corporation, Natick, Massachusetts, USA) through the stenotic anastomosis, but the guide wire could not be passed through the anastomosis (● **Figure 4**). A 6-Fr (Soehendra Biliary Dilation Catheters, Wilson-Cook, Winston-Salem, North Carolina, USA) dilator was advanced over the guide wire to dilate the gastropancreatic fistula, and then a 5-Fr, 5-cm-long pancreatic stent (Geenen Pancreatic Stent Set, Wilson-Cook, Winston-Salem, North Carolina, USA) was advanced over the wire and through the gastropancreatic fistula. The stent was placed in the pancreatic duct with the tip positioned in the proximal duct (● **Figure 5**, ● **Figure 6**). The patient's abdominal pain was rapidly relieved and his hyperglycemia had improved 1 month later.

Endoscopy_UCTN_Code_TTT_1AS_2AD

H. Sakamoto¹, M. Kitano¹, T. Komaki¹,
Y. Takeyama², M. Kudo¹

¹ Department of Gastroenterology and
Hepatology, Kinki University School of
Medicine, Osaka, Japan

² Department of Surgery, Kinki University
School of Medicine, Osaka, Japan

References

- 1 Amano H, Takada T, Ammori BJ et al. Pancreatic duct patency after pancreaticogastrostomy: long-term follow-up study. *Hepato-gastroenterology* 1998; 45: 2382–2387
- 2 Francois E, Kahalen M, Giovannini M et al. EUS-guided pancreaticogastrostomy. *Gastrointest Endosc* 2002; 56: 128–133
- 3 Gress F, Ikenberry S, Sherman S et al. Endoscopic ultrasound-directed pancreatography. *Gastrointest Endosc* 1996; 44: 736–739

Bibliography

DOI 10.1055/s-2007-966150
Endoscopy 2007; 39: E70–E71
© Georg Thieme Verlag KG Stuttgart · New York ·
ISSN 0013-726X

Corresponding author

M. Kitano, MD

Division of Gastroenterology and Hepatology
Department of Internal Medicine
Kinki University School of Medicine
377-2 Ohno-Higashi
Osaka-Sayama 589-8511
Japan
Fax: +81-72-367-2880
m-kitano@med.kindai.ac.jp