A 26-year-old woman underwent biliary sphincterotomy after a diagnosis of sphincter of Oddi dysfunction. A 3-cm monofilament standard sphincterotome with blended current was used and a zipper cut occurred, causing a tear at the 11-o’clock area of the ampulla (Fig. 1 and Video 1). Fluoroscopy showed a significant amount of free air in the retroperitoneal area. Initially, a gastroscope endoclipping device (HX-5LR-1; Olympus, Tokyo, Japan) and clips (HX-600-090L; Olympus) were deployed through the same side-viewing therapeutic duodenoscope (TJF 160; Olympus). There was marked difficulty in opening, rotating, and closing the clips; the endoscope elevator had to be locked at the open position during the deployment. Two clips were satisfactorily deployed before there was a malfunction of the clip handle (Fig. 2 and 3, Videos 1 and 2). The more easily deployed third endoclip was placed using a disposable system (HX-201LR-135; Olympus). Biliary and luminal decompression were achieved endoscopically. A broad spectrum antibiotic was given. The patient was able to resume her diet and all tubes were removed within 10 days. A computed tomography (CT) scan 3 months later showed no evidence of retroperitoneal air.

Most perforations following biliary sphincterotomy can be managed by nonoperative methods, including biliary and duodenal drainage [1]. If duodenal closure by surgery is planned, the tear is very difficult to access due to its retroperitoneal location. Hemoclipping has been well accepted for endoscopic control of many gastrointestinal perforations [2, 3]. It has been reported that duodenal closure using this technique via the side-viewing scope was more difficult than via the end-viewing scope [4, 5]. The limitations are the angle and stress created by the elevator of the scope and this in turn can lead to damage of the endoclipping devise. We therefore recommend using a disposable endoclipping device in this situation since it has a slimmer delivery system and is more flexible in manipulation.

References