Bridge-to-surgery gallbladder drainage with a lumen-apposing metal stent in malignant distal biliary obstruction: a choice tailored for the surgeon

A 70-year-old woman with cholangitis was diagnosed with a distal biliary stricture at another institution. The patient was referred to our center for biliary decompression and further evaluation. Endoscopic ultrasound (EUS) examination revealed wall thickening in the lower third of the common bile duct (CBD) and an intraluminal inhomogeneous hypoechoic lesion with irregular margins infiltrating the duodenal wall and the major papilla (Fig. 1). The gallbladder was distended, and the middle/upper third of the CBD was dilated up to 2 cm in diameter, with associated intrahepatic biliary tree dilation. Endoscopic retrograde cholangiopancreatography (ERCP) was unsuccessful owing to duodenal infiltration.

In order not to hamper a theoretical subsequent surgical biloenteric anastomosis (in the setting of a duodenopancreatectomy) we decided not to proceed with EUS-guided bile duct drainage (EUS-BD), even if technically feasible. In fact, an EUS-guided choledochoduodenostomy would have altered the integrity of the middle/upper third of the CBD, potentially conditioning future surgery, in case of resectability. Considering this, we opted for EUS-guided gallbladder drainage (EUS-GDB) from the gastric antrum with an 8 × 8 mm electrocautery-tipped lumen-apposing metal stent (LAMS) (AXIOS-EC; Boston Scientific, Marlborough, Massachusetts, USA) in a freehand fashion.

Same-session EUS-guided fine-needle biopsy confirmed malignancy of the lesion and a computed tomography scan assessed resectability (Fig. 2). The patient underwent Whipple duodenopancreatectomy 2 weeks later (Fig. 3 a, b, Video 1). Histologic assessment diagnosed a pT2/N2/Pn1/R0 poorly differentiated adenocarcinoma, and the postoperative course was uneventful.

ERCP and EUS-BD in patients with unresectable distal biliary stricture [1]. In resectable malignant distal biliary structures, EUS-GBD using an LAMS is a feasible bridge-to-surgery treatment if biliary decompression is needed. Actually, this technique preserves the integrity of the CBD, allowing the surgeon to perform a standard Whipple resection and a safe biloenteric anastomosis.
Fig. 3 Whipple duodenopancreatectomy. a Intraoperative view of the cholecystogastrostomy (*). The proximal flange of the lumen-apposing metal stent (LAMS) can be seen (arrow). b Surgical specimen showing the proximal flange of the LAMS (arrow), gastric antrum (*), first (**) and second (***) portion of the duodenum, and head of the pancreas (arrowhead).

Video 1 Endoscopic ultrasound-guided gallbladder drainage as a bridge-to-surgery biliary decompression in a patient with a resectable distal biliary stricture. Source for the graphical details in the video: Federico Amata

Acknowledgment
We thank Federico Amata for graphic assistance.

Competing interests
None

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DOI https://doi.org/10.1055/a-0754-1847
Published online: 7.11.2018
Endoscopy 2019; 51: 94–95
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

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Ligresti Dario et al. Gallbladder drainage with LAMS in malignant distal biliary obstruction… Endoscopy 2019; 51: 94–95