Endoscopic ultrasound-guided gastrojejunostomy does not prevent pancreaticoduodenectomy after long-term symptom-free neoadjuvant treatment

A 55-year-old woman was diagnosed with pancreatic head adenocarcinoma with hepatic artery and mesenteric vein contact. Due to cholangitis and papillary infiltration, an endoscopic ultrasound-guided choledochoduodenostomy (EUS-CD) was performed with an 8×8-mm electrocautery-enhanced lumen-apposing metal stent (LAMS; Hot Axios; Boston Scientific, Marlborough, Massachusetts, USA). One month later, she experienced gastric outlet obstruction (GOO) secondary to duodenal infiltration (▶ Fig. 1).

Endoscopically, the former EUS-CD LAMS was barely visible due to neoplastic infiltration (▶ Fig. 2). In order not to hinder biliary drainage, an EUS-guided gastrojejunostomy (EUS-GJ) was performed after fluid injection of the jejunum and free-hand placement of a 20×10-mm LAMS (Hot Axios), using wireless simplified (WEST) technique [1] (▶ Fig. 3). The patient resumed feeding on postoperative day (POD) 1 and was discharged on POD 5. She started neoadju-
vant PAXG treatment (nab-paclitaxel, gemcitabine, capecitabine, cisplatin) on POD 11. Computed tomography after 8 months showed significant regression of the lesion and its vascular contacts, and Whipple surgery was proposed after multidisciplinary discussion (▶Video 1). Surgical identification and disconnection of the EUS-GJ took no more than 20 seconds. The gastrojejunostomy site was cut on the central tract of the LAMS, and the stent was extracted (▶Fig. 4). The stomach was sutured using a linear-cutting stapler, the first jejunal loop was resected, and a termino-lateral gastrojejunostomy was performed (▶Fig. 5). Hepaticejunostomy was also not complicated by EUS-CD LAMS. Postoperative gastrointestinal series showed good gastric outlet and no contrast leakage. The patient was discharged after endoscopic management of one postoperative collection, and was feeling well after 96 days of follow-up.

While surgery after EUS-CD has been reported previously [3, 4], there is no published experience of pancreaticoduodenectomy following EUS-GJ. In this patient, EUS-CD+GJ provided 8 months free of jaundice and GOO and a rapid initiation of a neoadjuvant treatment, without affecting safety and oncological radicalism of subsequent surgery. Further evaluation of EUS-guided double bypass in the bridge-to-surgery scenario is therefore proposed.

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Competing interests

The authors declare that they have no conflict of interest.

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