A 55-year-old-female suffered from advanced obstructive jaundice due to resectable pancreatic cancer (▶Fig. 1). Preoperative biliary drainage via endoscopic retrograde cholangiopancreatography (ERCP) was attempted but unsuccessful due to duodenal obstruction. We then attempted endoscopic ultrasound-guided antegrade stenting using a novel uncovered self-expandable metal stent (SEMS) with an ultra-slim 5.4-Fr introducer and an ultra-tapered stiff tip (YABUSAME; Kaneka Medix, Osaka, Japan) (▶Fig. 2) after placement of a duodenal stent (▶Video 1). B2 was punctured with a 19-gauge needle via the stomach followed by contrast injection to depict the biliary tree (▶Fig. 3a). Then, a 0.025-inch angle-tip guidewire (INAZUMA; Kaneka Medix) was successfully manipulated antegrade into the duodenum through the stricture. Just after a removal of the needle, an introducer of a YABUSAME (10 × 60 mm) was inserted into the bile duct without any tract dilation and easily passed through the stricture (▶Fig. 3b). Finally, the stent was deployed (▶Fig. 3c). No adverse events had occurred for two weeks until surgery. EUS-guided biliary drainage includes bilioenterostomy, the rendezvous technique, and antegrade stenting. In preoperative biliary drainage, endoscopic ultrasound-guided bilioenterostomy seems unfavorable because the influence of a bilioenteric fistula on surgery is unknown [1]. Although the EUS-guided rendezvous technique and antegrade stenting do not form a fistula, both have pros and cons. In the rendezvous technique, tract dilation is usually unnecessary, but complicated steps including scope exchange, grabbing and pulling the guidewire, and cannulation are required. EUS-guided antegrade stenting is a simpler method; however, tract dilation with a dilator [2] or catheter [3] prior to insertion of a SEMS introducer is usually required and that increases a risk of the bile leak. In antegrade stenting, this novel introducer is likely to allow a SEMS to be placed just after needle removal and the bile leak and procedural time to be decreased. This method could be a useful alternative after failed ERCP in preoperative biliary drainage.

Endoscopy_UCTN_Code_TTT_1AS_2AD

Competing interests

The authors declare that they have no conflict of interest.

The authors

Saburo Matsubara, Keito Nakagawa, Kentaro Suda, Tetsuro Fujita, Takeshi Otsuka, Masashi Oka, Sumiko Nagoshi

Department of Gastroenterology and Hepatology, Saitama Medical Center, Saitama Medical University, Kawagoe, Saitama, Japan
Corresponding author

Saburo Matsubara, MD
Department of Gastroenterology and Hepatology, Saitama Medical Center, Saitama Medical University, 1981, Kamoda, Kawagoe-shi, Saitama 350-8550, Japan
Fax: +81-49-226-5284
saburom@saitama-med.ac.jp

References

doi:10.1002/jhbp.631


Bibliography

Endoscopy
DOI 10.1055/a-1524-1018
ISSN 0013-726X
published online 2021
© 2021. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

Fig. 3 Fluoroscopic views of endoscopic ultrasound-guided one-step antegrade stenting. a Cholangiogram after the puncture of B2 via the stomach depicted the dilated intrahepatic bile ducts and proximal common bile duct. A duodenal stent was placed in the second part of the duodenum (arrow). b Just after the removal of the needle leaving a guidewire in the duodenum, an introducer of an uncovered self-expandable metal stent was inserted into the duodenum over the guidewire. c The stent (10×60 mm) was deployed across the stricture.