Endoscopic biliary access after pancreaticoduodenectomy following Imanaga’s procedure

Endoscopic retrograde cholangiopancreatography (ERCP) is the technique of choice to drain the main biliary duct with a high degree of technical success [1]. However, in the case of a pancreaticoduodenectomy, endoscopic biliary access can be challenging. Imanaga’s procedure is a pylorus-preserving pancreaticoduodenectomy procedure with the duodenojejunal, pancreaticojejunal, and hepaticojejunal anastomosis reconstructed in that order on the jejunal limb (▶Fig. 1) [2, 3]. This procedure is thought to allow easier endoscopic access to the hepaticojejunal anastomosis [4]. Here we report two cases of endoscopic biliary access after Imanaga’s procedure. (▶Video 1). The first case is a 70-year-old man who underwent Imanaga’s procedure 4 months before for a duodenal lesion that could not be resected endoscopically. He subsequently had cholestasis with a stenosis of the biliary anastomosis. The anastomosis was hard to find with a duodenoscope, but thanks to immersion, the anastomosis was retrieved and cannulated with deployment of a self-expandable metal stent to calibrate the anastomosis (▶Fig. 2).

The second case is a 70-year-old man who underwent Imanaga’s procedure 1 month before for an intraductal papillary mucinous neoplasm. A stenosis of the biliary anastomosis occurred with cholestasis and one episode of cholangitis. Endoscopic management of the stenosis was decided. Despite intensive searching, the biliary anastomosis was not found. An echoendoscope was used to
visualize the common bile duct with a dilation of 7 mm and a clear stop. With a 19G needle, the biliary duct was punctured and opacified, and a guidewire was then positioned. To recalibrate the biliary anastomosis, a lumen-apposing metal stent was deployed, allowing satisfying biliary drainage (▶Fig. 3). Neither patient experienced any adverse event, and their cholestasis improved in the following days.

This e-video illustrates two successful endoscopic biliary accesses in patients with a history of pylorus-preserving pancreatecoduodenectomy following Imanaga’s procedure without the need of double-balloon endoscopy.

Endoscopy_UCTN_Code_TTT_1AR_2AZ

Competing interests

The authors declare that they have no conflict of interest.

The authors

Thomas Lambin1,2, Jérôme Rivory1, Mustapha Adham3, Florian Rostain1, Thierry Ponchon1, Pierre Lafeuille1, Mathieu Pioche1,2
1 Gastroenterology and Endoscopy Unit, Pavillon L, Edouard Herriot Hospital, Lyon, France
2 Inserm U1032, Labtau, Lyon, France
3 Digestive Surgery Unit, Edouard Herriot Hospital, Lyon, France

Corresponding author

Thomas Lambin, MD
Endoscopy Unit, Digestive Disease Department, Pavillon L, Edouard Herriot Hospital, 69437 Lyon Cedex, France
thomaslambin@hotmail.fr

References