An 85-year-old woman presented with right upper abdominal pain and fever. Examination revealed tenderness in the right hypochondrium with a positive Murphy’s sign. White cell count was 16.3 × 10⁹/L, but liver function was normal. Transabdominal ultrasound confirmed acute cholecystitis with a 6-mm cystic duct stone. Owing to the patient’s pre-existing Alzheimer’s disease and frail pre-morbid condition, we decided for endoscopic ultrasound-guided gallbladder drainage (EUS-GBD) after discussion with the patient’s main caregiver [1–3]. The procedure was performed in an endoscopy suite with fluoroscopy capabilities and the patient was placed in the prone position under conscious sedation (▶Video 1). A linear echoendoscope (GF-UCT260; Olympus, Tokyo, Japan) was advanced to the first part of the duodenum and a distended gallbladder up to 10 cm and a 6-mm cystic duct stone were identified (▶Fig. 1). There were no stones in the common bile duct. EUS-GBD was performed via direct puncture with a novel cautery-enhanced, lumen-apposing metal stent (LAMS) (Hanarostent Z-EUS IT; M.I. Tech, Gyeonggi-do, South Korea) (▶Fig. 2). This is a 12 mm (diameter) × 30 mm (length) fully-covered, lumen-apposing stent with an inter-flange distance of 22 mm. The opening and deployment of the proximal and distal flanges of the stent were fully controlled by the endoscopist. The opening of the distal flange was confirmed on endoscopic ultrasound (EUS) (▶Fig. 3), while the proximal flange was visualized endoluminally (▶Fig. 4). The procedure took 20 minutes and there was good drainage of purulent bile at the end. Abdominal X-ray confirmed a good stent opening and the presence of the air cholecystogram (▶Fig. 5). The patient’s fever subsided and her white cell count normalized by day two after the procedure and she was discharged with a one-week course of oral antibiotics.

The availability of a cautery-enhanced, endoscopist-deployed LAMS allows precise stent placement under EUS guidance to drain the gallbladder into the duodenum. It makes for safer stent deployment in tight spaces and reduces the need for an experienced assistant.

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Competing interests

AYB Teoh is a consultant for Boston Scientific, Cook Medical, Taewoong Medical, Microtech Medical, and M.I. Tech Medical Corporations. LWL Ong, SM Chan, and HC Yip declare no conflicts of interest.
The authors

Lester Wei Lin Ong1,2, Shannon Melissa Chan1, Hon Chi Yip1, Anthony Yuen Bun Teoh1
1 Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong
2 Department of General Surgery, Sengkang General Hospital, Singapore

Corresponding author

Anthony Yuen Bun Teoh, MD
Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Central Avenue, 999077 Hong Kong, China
Fax: +852-3505-7974
anthonyteoh@surgery.cuhk.edu.hk

References


Bibliography

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