Acute cholecystitis occurs in 4%–7% of patients with a covered metallic stent (CMS) placed in the bile duct [1, 2]. Percutaneous transhepatic gallbladder drainage, which involves an external drainage tube, decreases the ability of the patient to carry out their normal daily activities. Recently, endoscopic ultrasound (EUS)-guided drainage has been employed successfully for hepatogastrostomy, bilioduodenostomy, and pancreatogastrostomy [3–5]. We report here a patient who underwent EUS-guided gallbladder drainage for acute cholecystitis caused by CMS placement.

A 71-year-old man with unresectable pancreatic cancer underwent deployment of a CMS for obstructive jaundice. On the eighth post-procedure day, he complained of abdominal pain and developed fever, associated with an increase in white blood cell counts and raised serum level of C-reactive protein. Computed tomography revealed an enlarged gallbladder, suggesting acute cholecystitis and requiring continuous drainage of the gallbladder. Therefore, after obtaining informed consent, we carried out EUS-guided gallbladder drainage. An echoendoscope (GF-UCT240-AL5; Olympus, Tokyo, Japan) was introduced into the stomach, and a 19-gauge needle (Echo-Tip; Wilson-Cook, Winston-Salem, North Carolina, USA) was used to puncture the gallbladder (Fig. 1) and create a gastro-gallbladder fistula. The infected bile was immediately aspirated via the needle and the gallbladder was irrigated with a contrast medium containing an antibiotic. A 0.035-inch guide wire (Revo-wave, Olympus, Tokyo, Japan) was passed through the needle under fluoroscopic guidance until it reached the gallbladder; the guide wire was coiled within the gallbladder (Fig. 2). Three biliary dilation catheters (6 Fr, 7 Fr, and 9 Fr; Soehendra

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**Fig. 1** Gallbladder punctured under endoscopic ultrasound guidance before placement of the guide wire.

**Fig. 2** Fluoroscopic image showing the coiled guide wire in the gallbladder.

**Fig. 3** Fluoroscopic image showing the placement of the stent through the gastro-gallbladder fistula. The tip of the stent was positioned in the gallbladder.

**Fig. 4** Endoscopic view of the stent inserted into the gallbladder from the antrum of the stomach.
Biliary Dilation Catheters, Wilson-Cook, Winston-Salem, North Carolina, USA) were serially advanced over the guide wire to dilate the diameter of the tract. A pigtail stent (diameter 7 Fr; length 4 cm) was placed over the guide wire to bridge the gallbladder and the antrum of the stomach (Fig. 3, 4). There were no procedure-related complications. The patient’s fever and abdominal pain resolved rapidly and laboratory data showed improvement 5 days later. Although the stent was kept in place for 6 months without any additional intervention, such as removal or exchange of the stent, there were no recurrent symptoms.

**References**


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