Stomal dilation of a rigid gastrostomy for endoscopic retrograde cholangiopancreatography (ERCP): novel technique using a standard duodenoscope

Therapeutic endoscopic retrograde cholangiopancreatography (ERCP) via a gastrostomy by sternal balloon dilation through a surgical or radiological gastrostomy site has been described in a few cases [1–3]. We report here a novel technique for dilating a rigid percutaneous endoscopic gastrostomy (PEG) stoma for therapeutic ERCP.

A 69-year-old man with bile duct stones was hospitalized for acute cholangitis. A gastrostomy feeding tube had been inserted 9 years ago because of progressive amyotrophic lateral sclerosis. Since peroral standard duodenoscope insertion was impossible, we attempted ERCP via the gastrostomy using a large balloon with a 15-mm diameter; however, this was unsuccessful because of the comparatively rigid stoma. We therefore carried out tentative 5-Fr biliary stenting [4] via the gastrostomy using an ultraslim endoscope (Fig. 1). After 3 days we tried dilating the gastrostomy stoma again using the following novel technique under transnasal endoscopy guidance. After placing four suture fasteners (Direct Ideal PEG kit, Olympus, Tokyo, Japan) around the existing gastrostomy in the stomach to avoid perforation, we made an incision (approximately 4 mm) in the stoma at the 12 o’clock portion using a cautery knife. The stoma was dilated using a thoracor dilator (Thoracoport trocar, inner stylet diameter 11.5 mm; Auto Suture Company Division, Chesterland, Ohio, USA) (Fig. 2) to allow the passage of a therapeutic duodenoscope (JF-260V, Olympus). The duodenoscope was passed into the second portion of the duodenum through the trocar (Fig. 3). After removal of the biliary stent, we carried out endoscopic sphincterotomy and stone removal using a basket catheter, without any complications (Fig. 4).

To our knowledge, this is the first report of a stomal dilation technique for ERCP via PEG using a standard duodenoscope. We believe this novel technique may allow ERCP to be carried out via the gastrostomy even in patients with a rigid stoma.

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References
3 Baron TH, Vickers SM. Surgical gastrostomy placement as access for diagnostic and therapeutic ERCP. Gastrointest Endosc 1998; 48: 640 – 641

Bibliography
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Corresponding author
T. Itoi, MD, PhD
Department of Gastroenterology and Hepatology
Tokyo Medical University
6-7-1 Nishishinjuku
Shinjuku-ku
Tokyo 160-0023
Japan
Fax: +3-5381-6654
itoi@tokyo-med.ac.jp

Fig. 4  a After endoscopic sphincterotomy, the stones were removed using a basket catheter. b Endoscopic image showing small black stones.