Another option for biliary access in post-bypass patient: intentional disruption of a gastric staple line

Obese and post-Roux-en-Y gastric bypass (RYGB) patients are at increased risk of cholelithiasis and associated biliary disorders [1 – 3]. Because of the complicated postsurgical anatomy, endoscopic retrograde cholangiopancreatography (ERCP) may be more difficult, requiring deep enteroscopy or laparoscopic assistance. We report a case of intentional disruption of the gastric remnant-excluded stomach staple line to gain access to the duodenum for treatment of choledocholithiasis.

A 72-year-old woman with past medical history of recent four-vessel cardiac artery bypass, oxygen-dependent chronic obstructive pulmonary disease, dialysis-dependent end-stage renal disease, and a Roux-en-Y gastric bypass (with cholecystectomy) 30 years ago was admitted at a local hospital with gallstone pancreatitis. She was treated with typical therapy and clinically improved, but on hospital day 3 she was noted to have a persistently elevated total bilirubin of 2.7mg/dL. Magnetic resonance pancreatography (MRCP) showed a dilated common bile duct (12 mm) with choledocholithiasis. ERCP was attempted at the local facility, but failed as the jejuno-jejunal anastomosis could not be reached, prompting transfer to our facility. On repeat ERCP, we accessed to the jejuno-jejunal anastomosis, which was deep-
ly intubated to 60 cm, but could not be advanced to the level of the papilla. On removing the colonoscope, scant bile was noted in the gastric pouch. After probing with a sphincterotome, a small fistula tract was noted between the gastric pouch and the excluded stomach along the staple line (● Fig. 1), verified fluoroscopically by wire and contrast injection (● Fig. 2). The fistula tract from the gastric pouch to the excluded stomach was not closed to allow repeat access if necessary. The patient did well and recovered from the episode.

Post-RYBG anatomy can make ERCP difficult, occasionally requiring deep-enteroscopy techniques or laparoscopic assistance to evaluate and treat biliary disorders. Here we have presented a case of intentionally disrupting the staple line excluding the bypassed stomach in a post-RYGB patient to facilitate therapeutic ERCP.

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