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 2.7 mg/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 jejunoo-jejunal anastomosis could not be reached, prompting transfer to our facility.

On repeat ERCP, we accessed to the jejunoo-jejunal anastomosis, which was deep-
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-RYGB 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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J. M. Levenick, T. B. Gardner

Section of Gastroenterology and Hepatology, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, USA

References

Bibliography

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Corresponding author

J. M. Levenick
Section of Gastroenterology and Hepatology, Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756
USA
Fax: +603-650-5225
John.m.levenick@hitchcock.org

Fig. 5 Stone extraction.