Successful endoscopic dilation of severe bilioenteric strictures with a wire-guided diathermic dilator and short-type single-balloon enteroscope

Recently, balloon enteroscopy has made possible the use of endoscopic approaches to the surgically reconstructed intestine [1–4], so that hepaticojunostomy strictures can be treated endoscopically. We describe the successful endoscopic dilation of a severe hepaticojunostomy stricture with a wire-guided diathermic dilator (6-Fr, 180-cm Cysto-Gastro-Set; Endo-flex, Voerde, Germany) (Fig. 1). A 66-year-old woman underwent pylorus-preserving pancreaticoduodenectomy for cancer of the pancreatic head. Cholangitis due to bilioenteric stricture developed at the third month after surgery. A short-type, single-balloon enteroscope (SIF-Y0004V01; Olympus Medical Systems, Tokyo, Japan) was used to perform balloon enteroscopy-assisted endoscopic retrograde cholangiopancreatography (ERCP). A 0.025-inch guidewire could pass through the stricture, but an ERCP imaging catheter could be passed through the stricture. A guidewire was placed in a hepatic duct, and the anastomotic stricture was electrically dilated with a 6-Fr Cysto-Gastro-Set. After the dilation procedure, an imaging catheter could be passed through the stricture. The anastomosis was dilated with a 6.8-Fr Quantum TTC Biliary Balloon Dilator 6mm in diameter (QBD-6X3; Cook Medical, Bloomington, Indiana, U.S.A), after which the cholangitis decreased. There were no adverse events. The stricture was classified as a type A1 stricture according to the classification of Mönkemüller & Jovanovic [4]. In patients who undergo balloon enteroscopy-assisted ERCP for hepaticojejunoctomy strictures, a tangential approach to the stricture site is often used. When a needle-knife is used, it is difficult to perform coaxial dilation from a tangential approach (Fig. 2b); this technique has caused anastomotic perforation [5] and is therefore not recommended. We therefore use a 6-Fr Cysto-Gastro-Set for the endoscopic dilation of anastomotic strictures (Fig. 2a), which facilitates dilation along the same axis as the guidewire [5]. Our results suggest that a 6-Fr wire-guided diathermic dilator may be useful for anastomotic dilation in patients with severe hepaticojunostomy strictures.

Endoscopy_UCTN_Code_TTT_1AR_2AG

Competing interests: None

Fig. 1 A 6-Fr wire-guided diathermic dilator (Cysto-Gastro-Set), with a working length of 180 cm and a maximum diameter of 2.0 mm, can be used to dilate severe hepaticojunostomy strictures.

Fig. 2 A wire-guided diathermic dilator can easily be used to perform coaxial dilation from a tangential approach. a The needle-knife, and therefore the direction of electroincision, cannot always be aligned exactly along the axis of the guidewire.

Eiji Miyata, Hiroshi Yamauchi, Mitsuhiro Kida, Kosuke Okuwaki, Shiro Miyazawa, Tomohisa Iwai, Wasaburo Koizumi

Department of Gastroenterology, Kitasato University, East Hospital, Sagamihara City, Kanagawa, Japan

References

1 Yamauchi H, Kida M, Okuwaki K et al. Short-type single balloon enteroscope for endoscopic retrograde cholangiopancreatography with altered gastrointestinal anatomy. World J Gastroenterol 2013; 19: 1728–1735
Kawakami H, Kuwatani M, Kawakubo K et al. Transpapillary dilation of refractory severe biliary stricture or main pancreatic duct by using a wire-guided diathermic dilator (with video). Gastrointest Endosc 2014; 79: 338–343

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1391240
Endoscopy 2015; 47: E94–E95
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Hiroshi Yamauchi, MD
Department of Gastroenterology
Kitasato University East Hospital
2-1-1 Asamizodai, Minami-ku, Sagamihara
Kanagawa 252-0380
Japan
Fax: +81-42-749-8690
yhiroshi@kitasato-u.ac.jp