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

A 66-year-old woman underwent pylorus-preserving pancreaticoduodenectomy for cancer of the pancreatic head. Cholangitis due to bilioenteric stricture according to the classification of Mönkemüller & Jovanovic [4]. In patients who undergo balloon entero- scope-assisted ERCP for hepaticojejunostomy 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 (Video 2a); this technique has caused anastomotic perforation [5] and is not considered optimal. We therefore use a 6-Fr Cysto-Gastro-Set for the endoscopic dilation of anastomotic strictures (Fig. 2b), 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 hepaticojejunostomy strictures.

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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 hepaticojejunostomy strictures.

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

References
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Recently, balloon enteroscopy has made possible the use of endoscopic approaches to the surgically reconstructed intestine [1–4], so that hepaticojejunostomy strictures can be treated endoscopically. We describe the successful endoscopic dilation of a severe hepaticojejunostomy 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 enteroscope-assisted endoscopic retrograde cholangiopancreatography (ERCP). A 0.025-inch guidewire could pass through the stricture, but an ERCP imaging catheter could not. 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, Kanagawa, Japan) after which the cholangitis decreased (Video 1). 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 entero- scope-assisted ERCP for hepaticojejunostomy 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 (Video 2b); this technique has caused anastomotic perforation [5] and is not considered optimal. 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 hepaticojejunostomy strictures.

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Video 1

Endoscopic dilation of a severe bilioenteric stricture with a wire-guided diathermic dilator.

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