Double-balloon enteroscopy-assisted endoscopic retrograde cholangiography for the treatment of a strictured Roux-en-Y hepaticojejunal anastomosis

A 49-year-old patient underwent cholecystectomy and Roux-en-Y hepaticojejunal anastomosis (Fig. 1) for Mirizzi’s syndrome. Jaundice, pruritus, choluria, and acholia developed 4 months later. The total serum bilirubin was 21 mg/dL, and magnetic resonance cholangiopancreatography (MRCP) demonstrated intrahepatic bile duct dilation and anastomotic stricture.

Double-balloon enteroscopy was performed, and the hepaticojejunal anastomosis was reached. A pinpoint anastomotic stricture was noted (Fig. 2). After diathermic debridement of the stricture, it was possible to traverse the stricture with a 0.035-inch hydrophilic tip guidewire (Fig. 3a, b). Cholangiography demonstrated a marked dilation of the intrahepatic biliary tree and a long (10-mm) anastomotic stricture. No filling defect compatible with stones was detected. A 12- to 15-mm balloon (Fig. 4) was introduced over the wire, and the stenosis was successfully dilated to 15 mm (Fig. 5). The serum bilirubin levels normalized in 5 days.

Roux-en-Y hepaticojejunostomy stricture occurs in 10% to 30% of patients and requires prompt intervention [1]. Percutaneous and surgical approaches are the standard treatment options but may be associated with significant morbidity [2, 3]. In this scenario, balloon overtube-assisted enteroscopy provides an option to access the hepaticojejunal anastomosis. As illustrated by our case, the technical success rate of balloon overtube-assisted enteroscopy for postoperative retrograde cholangiography may be as high as 85%, and this technique should be considered as the first option for patients requiring postoperative endoscopic retrograde cholangiopancreatography (ERCP) [4–6].

References
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Gabriela F. Paduani1, Adriana Vaz Saflattie-Ribeiro2, Matheus Cavalcante Franco2, Fauze Maluf-Filho2
1 Cancer Institute, University of São Paulo, São Paulo, SP, Brazil
2 Department of Gastrointestinal Endoscopy, University of São Paulo, São Paulo, SP, Brazil

Fig. 1 Roux-en-Y gastric bypass in a 49-year-old patient with Mirizzi’s syndrome.
Fig. 2 Endoscopic view of a pinpoint stricture of the Roux-en-Y hepaticojejunal anastomosis.
Fig. 3 a, b Diathermic debridement of the stricture makes it possible to traverse the stricture with a 0.035-inch hydrophilic tip guidewire.
Fig. 4 Balloon dilation of the stricture.
Fig. 5 Final aspect after endoscopic therapy.

**Bibliography**


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**Corresponding author**

**Gabriela F. Paduani, MD**

Cancer Institute of University of São Paulo – Endoscopy

Av. Arnaldo, 251

Cerqueira Cesar

São Paulo 01246-000

Brazil

Fax: +55-11-3893-2000

gabrielapaduani@gmail.com