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 hepaticojejunostomy (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 hepaticojejunostomal 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 stricture 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 hepaticojejunostomal 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].

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Competing interests: None

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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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