Traumatic bile leak in war-injured Syrians: five patients treated by ERCP

About 20 months ago, an open letter was published in The Lancet calling for patients from the Syrian civil war to be treated [1]. Specifically, the letter said, “It is our professional, ethical, and moral duty to provide treatment and care to anyone in need”.

The ongoing civil war in Syria has led to what is arguably one of the world’s worst humanitarian crises. According to the World Health Organization (WHO), 37% of Syrian hospitals have been destroyed, 20% are severely damaged, and more than 70% of Syria’s medical professionals have fled the country [1,2]. Since the start of this conflict, approximately 700 Syrian war-injured, most of them civilian non-combatants, have received medical treatment in Israel [3,4]. Between December 2013 and October 2014, five Syrian civilians with multitrauma, including penetrating liver injuries complicated by bile leakage, were transferred to our medical center for further evaluation and treatment (Table 1).

All of the patients underwent diagnostic and therapeutic endoscopic retrograde cholangiopancreatography (ERCP). Bile leaks were diagnosed and treated endoscopically by biliary sphincterotomy either alone (n = 2) or combined with biliary stent insertion (n = 3). All of the external bile leaks (via percutaneous abdominal drains or chest tube), including that in a patient who had a biliopleural fistula (Fig. 1), resolved within 2–5 days of endoscopic intervention (Table 1). The external drains were removed 2–3 days after the cessation of the bile leakage.

After a period of hospitalization ranging from 12 to 30 days, once their general condition had been stabilized, all of the patients were transferred back across the border with appropriate recommendations, including for removal of any stents that had been inserted. Unfortunately, we do not have long-term clinical or endoscopic follow-up.

Table 1: Details of the five war-injured Syrian civilians with bile leaks and the treatment they underwent.

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Age, years</th>
<th>Sex</th>
<th>Liver injury</th>
<th>Type of bile leak</th>
<th>Endoscopic intervention</th>
<th>Short-term outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27</td>
<td>Male</td>
<td>Shrapnel, grade 3</td>
<td>High grade, common hepatic duct</td>
<td>Sphincterotomy with plastic stent insertion (10 Fr, 12 cm)</td>
<td>Resolution of external biliary leakage</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>Female</td>
<td>Shrapnel, grade 3–4</td>
<td>Low grade, segments 6–7</td>
<td>Sphincterotomy</td>
<td>Resolution of external biliary leakage</td>
</tr>
<tr>
<td>3</td>
<td>36</td>
<td>Female</td>
<td>Shrapnel, grade 2–3</td>
<td>Low grade, segment 6</td>
<td>Sphincterotomy</td>
<td>Resolution of external biliary leakage</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>Male</td>
<td>Crash, shrapnel</td>
<td>Low grade, peripheral with biliopleural fistula</td>
<td>Sphincterotomy with plastic stent insertion (7 Fr, 7 cm)</td>
<td>Resolution of external biliary leakage</td>
</tr>
<tr>
<td>5</td>
<td>15</td>
<td>Male</td>
<td>Shrapnel, grade 3</td>
<td>High grade, segments 5–6</td>
<td>Sphincterotomy with plastic stent insertion (10 Fr, 10 cm)</td>
<td>Resolution of external biliary leakage</td>
</tr>
</tbody>
</table>

Fig. 1: Images during endoscopic retrograde cholangiopancreatography (ERCP) carried out on a 12-year-old boy with spinal, chest, and abdominal injuries who was noted to have biliary fluid draining from his chest tube (biliotorax) showing: a) the appearance as contrast was being injected; b) a bile leak from the subsegmental biliary pedicle and a biliopleural fistula; c) a stent in situ.
associated with multiorgan trauma and infection or sepsis.

A high risk surgical repair has been the conventional mode of therapy for post-traumatic bile leaks. Recent data has shown that ERCP is effective (> 80% rates of healing) in managing bile leaks secondary to blunt or sharp traumatic liver injuries, using transpapillary endoscopic sphincterotomy, biliary stenting, or both. There is currently no consensus on which ERCP maneuver is superior [5].

As the war rages on, we will continue to provide medical care to anyone in need, just as was called upon for these patients.

Endoscopy_UCTN_Code_TTT_1AR_2AZ

Competing interests: None

Iyad Khamaysi, Alain Suissa, Kamal Yassin, Ian M. Gralnek

Department of Gastroenterology and the Advanced Endoscopy Procedures Unit, Rambam Health Care Campus and Rappaport Faculty of Medicine, Technion-Israel Institute of Technology, Haifa, Israel

References


Bibliography

DOI http://dx.doi.org/10.1055/s-0034-1392656
Endoscopy 2015; 47: E426–E427
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author

Iyad Khamaysi, MD
Department of Gastroenterology
Rambam Health Care Campus
Rappaport Faculty of Medicine, Technion-Israel Institute of Technology
Haifa
Israel
Fax: +972-4-7773058
K_iyad@rambam.health.gov.il