A novel method for endoscopic ultrasound-guided pancreatic rendezvous with a microcatheter

A 69-year-old woman with chronic pancreatitis and recurrent pancreatic-type abdominal pain underwent computed tomography, which showed dilatation of the pancreatic duct. Subsequent endoscopic retrograde cholangiopancreatography revealed a fibrotic papillary stenosis preventing cannulation of the pancreatic duct.

Endoscopic ultrasound (EUS)-guided rendezvous was attempted (Video 1). The pancreatic duct was punctured with a 19-gauge needle (Expect; Boston Scientific, Natick, Massachusetts, USA). A 0.025-inch angulated-tip guidewire (Visi-Glide; Olympus America, Center Valley, Pennsylvania, USA) was then advanced into the pancreatic duct but could not pass through the stenosis to the duodenal lumen. Because of the possible risk for fragmentation of the guidewire during manipulation, the needle was removed and a 150-cm, 3-Fr microcatheter (Renegade Hi-Flo; Boston Scientific) was inserted into the pancreatic duct over the guidewire (Fig. 1). The microcatheter was smoothly inserted and easily advanced to the prepapillary area and the guidewire removed (Fig. 2).

Contrast was injected to better define the cephalic duct (Fig. 3). A 0.025-inch straight-tip guidewire was inserted through the microcatheter (Fig. 4) and after manipulation was advanced through the stenosis into the duodenum (Fig. 5). The pancreatic rendezvous was complet-
ed, and a 7-Fr pancreatic stent (Advanix; Boston Scientific) was placed (Fig. 6).

The success rate for pancreatic rendezvous reaches only 50% in published series [1]. Manipulation of the guidewire, the most significant limiting factor [2], is hampered by the sharp needle grind, which can block and cut the tip of the guidewire. An enhanced protocol for biliary rendezvous with a 4-Fr catheter has been proposed [3]; however, this is the first report of EUS-guided rendezvous with a 3-Fr microcatheter. The microcatheter, taken from the interventional radiology armamentarium, is thinner than the 19-gauge needle, avoids dilation of the transmural track, and facilitates manipulation of the 0.025-in guidewire, guidewire exchange, and contrast injection. These advantages can improve the success rate of EUS-guided rendezvous.

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Juan Vila1, Carlos Huertas2, Bruno Gonçalves3, Alba Cebrián1, David Ruiz-Clavijo1, Belén González de la Higuera1, Carlos Prieto1

1 Endoscopy Unit, Gastroenterology Department, Complejo Hospitalario de Navarra, Pamplona, Spain
2 Gastroenterology Department, Hospital Universitario Josep Trueta, Gerona, Spain
3 Gastroenterology Department, Hospital de Braga, Braga, Portugal

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Corresponding author
Juan J. Vila, MD
Endoscopy Unit, Gastroenterology Department Complejo Hospitalario de Navarra C/ de Irunlarrea 3
31008 Pamplona
Navarra
Spain
Fax: +34-848-422303
juanvila@gmail.com

Fig. 4 A 0.025-in straight-tip guidewire (arrow) is advanced through the microcatheter and comfortably manipulated.

Fig. 5 With manipulation, the guidewire finally reaches the duodenal lumen through the stenosis, and the rendezvous procedure is completed.

Fig. 6 A 7-Fr pancreatic stent is finally placed, and the patient is asymptomatic when discharged 24 hours later.