A 35-year-old female patient receiving palliative chemotherapy for advanced pancreatic neuroendocrine tumor was referred to hospital with fever and obstructive jaundice. Computed tomography demonstrated a well-defined, 4 × 4.5-cm, contrast-enhanced mass in the head of the pancreas, associated with liver metastases and peripancreatic lymph nodes. The common bile duct (CBD) was markedly dilated (25 mm), and laboratory data were compatible with cholangitis. She was referred for biliary drainage via endoscopic retrograde cholangiopancreatography (ERCP). However cannulation of the CBD failed because of neoplastic infiltration of the ampullary region. Endoscopic ultrasound (EUS) (Fig. 1) was performed to guide needle puncture (19G Expect; Boston Scientific) from the duodenal bulb. Then a guidewire (0.0035-inch Jagwire; Boston Scientific) was inserted into the CBD and advanced antegradely and exteriorized through the papilla (Fig. 2). Following this, a parallel cannulation of the CBD through the papillary orifice with a second guidewire (0.0025-inch Jagwire; Boston Scientific) preloaded in a cannulatome was possible (Fig. 3); this was advanced alongside the first guidewire but from the opposite direction. A self-expandable metallic stent (100 × 60 mm partially covered Wallflex; Boston Scientific) was then successfully deployed (Fig. 4). Biliary decompression was achieved (Video 1). The procedure took 30 minutes and no immediate adverse event occurred. The patient was discharged after 4 days. There were no signs of cholangitis 6 weeks later.
scope channel, with risk of loss of the puncture or guidewire [3,4]. As illustrated by this case, EUS-BD with cannulation by a second guidewire, advanced parallel but in the opposite direction (i.e., “antiparallel”) to the first guidewire, may be considered prior to the conventional technique, because it seems to be easier and safer by avoiding the rendezvous step.

Endoscopy_UCTN_Code_TTT_1AS_2AD

Competing interests: None

Maria Sylvia I. Ribeiro, Matheus Cavalcante Franco, Fauze Maluf-Filho
Cancer Institute of São Paulo, University of São Paulo, São Paulo, Brazil

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DOI http://dx.doi.org/10.1055/s-0041-110595
Endoscopy 2016; 48: E12–E13
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Fauze Maluf-Filho, MD, PhD
Cancer Institute of São Paulo
University of São Paulo
Av. Dr Arnaldo, 215. São Paulo
SP, Brazil 01255-000
Fax: +55-11-38932296
fauze.maluf@terra.com.br

Ribeiro Maria Sylvia I et al. An easier option for EUS-guided biliary drainage: use of two antiparallel guidewires... Endoscopy 2016; 48: E12–E13