Duodenal perforation as complication of endoscopic retrograde cholangiopancreatography (ERCP) is a rare but serious secondary event with an incidence of 0.6% – 0.99% [1].

The most dangerous type of perforation is that categorized as type I in the classification by Stapfer et al. [2] and usually located in the lateral or medial duodenum wall. This is associated with high mortality rates (28% – 47%) [3] and requires surgical intervention in over 86% of cases [4]. Recently, the European Society of Gastrointestinal Endoscopy (ESGE) has recommended immediate closure during endoscopy, which is usually successful in 22% of attempts [5]. Case reports describe many different methods, but the most frequently used technique is application of endoclips with forward-viewing endoscopes [6]. Other techniques include the use of over-the-scope clips (OTSCs; Ovesco, Tübingen, Germany, and Aponos, Kingston, New Hampshire, USA) as well as glues, meshes, biologic or synthetic plugs, and endoloop plus clipping. However, with all these methods it is necessary to replace the lateral-viewing endoscope with a forward-viewing one.

The patient was an 86-year-old man with multiple co-morbidities including metastatic prostate cancer of the lung and the liver hilum, the latter having been treated with a plastic biliary stent 2 months previously. The patient was not a surgical candidate and presented for stent exchange, with a planned replacement of the plastic stent by a self-expandable metal stent (SEMS). Unfortunately, during the endoscopy a perforation of 13 mm diameter was clearly visible in the lateral wall of the duodenum (Fig. 1 a, Fig. 1 b). Immediately after visual identification of the perforation, we thoroughly aspirated the duodenal contents. Without exchang-
ing the lateral-viewing duodenoscope, we proceeded to close the perforation using four through-the-scope (TTS) endoclips (Instinct; Cook Medical, Limerick, Ireland) (Fig. 2).

The patient remained in hospital, with a nasogastric tube, intravenous antibiotics, proton pump inhibitor (PPI) medication, and parenteral feeding for 6 days. The patient denied any abdominal pain, fever, or sequelae of infection. Subsequent enterography with Gastrografin contrast demonstrated no leak and the patient was discharged home (Fig. 3).

The follow-up ERCP 5 weeks later demonstrated the complete healing of the duodenal wall. During this second ERCP, the plastic prosthesis was successfully replaced with a covered metal stent (Hanarostent, 10 Fr × 100 mm; M.I.Tech, France) without any adverse event (Fig. 4a, b).

This report demonstrates that even large iatrogenic type I duodenal perforations can be safely, quickly and successfully closed with TTS endoclips through the duodenoscope. In this case carbon dioxide (CO₂) gas was not used for insufflation but there is evidence that CO₂ insufflation can improve outcomes particularly in cases complicated by endoscopic perforation.

Competing interests: None

Alvaro Martinez-Alcalá García1,2, Felipe R. Martinez-Alcalá García1, Jose M. Perez Pozo1, Jose A. Ciria Avila1, Felipe Martinez Alcalá1

1 CIDMA (Centro de Innovaciones Digestivas Martinez Alcalá), Seville, Spain
2 Hospital Universitario de Nuestra Señora de Valme, Seville, Spain

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DOI http://dx.doi.org/10.1055/s-0042-103421
Endoscopy 2016; 48: E86–E87
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
Alvaro Martinez-Alcalá Garcia, MD
Division of Gastroenterology and Hepatology
Hospital Universitario de Nuestra Señora de Valme, Seville, Spain
Carretera Cadiz s/n
Bellavista, Seville
Spain
Fax: 34-66-2372216
alvaromalcala@gmail.com