Direct peroral cholangioscopy (DPOCS) is a useful and effective technique for diagnosis and therapy of biliary tract disease [1–3]. No instances of a fatal systemic gas embolism developing during DPOCS under carbon dioxide (CO₂) insufflation have yet been reported.

A 68-year-old woman was admitted to our hospital with a complaint of hepatolithiasis (Fig. 1). She had undergone Roux-en-Y hepaticojejunostomy for choledochal cysts 34 years previously. We performed DPOCS using a short-type double-balloon enteroscope (DBE), an ultraslim endoscope, and an endoscopic CO₂ regulator (EC-450BII, EG-580NW, GW-1, respectively; Fujifilm Corp., Tokyo, Japan) while the patient was kept adequately sedated with midazolam.

We planned to perform lithotripsy of the hepatolith using a Holmium:YAG laser. After we had reached the anastomosis using the DBE, attempts to extract the stones through the DBE using balloon or basket catheters failed (Fig. 2 a). We therefore decided to perform DPOCS with an ultraslim endoscope passed through an overtube using a previously described method (Fig. 2 b) [3]. The balloon attached to the overtube remained inflated from the time that we reached the anastomosis until the end of the procedure.

We first confirmed the hepatolith was present (Fig. 3 a). We then prepared the Holmium:YAG laser for lithotripsy for 5 minutes, while we aspirated pus and mucus discharged from the peripheral bile duct near the hepatolith. As we fractured the hepatolith with the Holmium:YAG laser (Fig. 3 b), the patient suddenly went into shock and had a cardiac arrest. Despite immediate cardiopulmonary resuscitation and injection of flumazenil, she died. A computed tomography (CT) scan performed during resuscitation revealed multiple gas emboli in the systemic arteries and veins (Fig. 4).

Pathological examination later revealed hepatic abscesses, inflammation surrounding the hepatolith, intravascular gas, and systemic gas emboli [4]. There was no evidence of a patent foramen ovale [5]. The cause of death was systemic gas embolism. We believe aspiration of pus and mucus prior to lithotripsy may have opened a pre-existing biliovenous shunt.

Endoscopists should take the possibility of fatal gas embolism into consideration during DPOCS even under CO₂ insufflation. The extent of insufflation should be the absolute minimum required.
Competing interests: None

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References


Bibliography
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Fig. 4 Computed tomography (CT) scan during resuscitation showing multiple gas emboli in the systemic arteries and veins of: a the brain; b the heart.