Percutaneous transhepatic biliary drainage-assisted, endoscopic ultrasound-guided hepaticoduodenostomy for isolated complete right intrahepatic duct obstruction

A 43-year-old woman presented with epigastric pain and cholestatic liver dysfunction after open cholecystectomy. Magnetic resonance cholangiopancreatography (MRCP) showed an abrupt cut-off of the right anterior segmental bile duct, suggesting a transection injury following the cholecystectomy. When a transection injury has occurred, surgical reconstruction with biliary enteric anastomosis is indicated [2, 3]. PTBD was initially performed for biliary decompression. As the remaining bile duct was too short to be connected to the jejunum, the surgeon suggested segmental liver resection instead of hepaticojejunostomy; however, the patient refused surgical management, so we performed EUS-guided drainage with the assistance of PTBD.

An echoendoscope was positioned close to the blind end of the transected bile duct, with the PTBD catheter being used as the target. An EUS-guided puncture (19-gauge needle; Boston Scientific) was performed into the blind end of bile duct, which was confirmed by contrast injection. A 0.025-inch hydrophilic guidewire (● Video 1); a needle knife and 4-mm balloon catheter were then used for tract dilation. A fully covered self-expanding metal stent (6 mm in diameter, 7 cm in length; M.I. Tech, Seoul) was introduced and positioned in the right anterior IHD. A new anastomosis between the transected IHD and the duodenum was therefore successfully created. The PTBD catheter was removed 3 days later after it had been confirmed that the stent was functioning well (● Fig. 2; ● Video 1).

The metal stent was removed 11 months later. A retrograde cholangiogram through the fistula tract 6 months after removal of the stent showed durable patency (● Fig. 3; ● Video 1).

Endoscopy_UCTN_Code_TTT_1AR_2AJ

Competing interests: None

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DOI http://dx.doi.org/10.1055/s-0042-117223

Endoscopy 2016; 48: E317–E318

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ISSN 0013-726X

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