Rescue technique using a diathermic dilator for an unremovable stent in malignant perihilar biliary obstruction

Endoscopic biliary stenting is a useful and safe technique for malignant biliary obstructions. A plastic stent is frequently used because of its low cost and ease of deployment. However, it is occasionally difficult to remove a plastic stent because of severe stricture. We describe a rescue technique for immovable plastic stents, using a diathermic dilator in a case of perihilar biliary obstruction.

A 63-year-old woman with jaundice due to hilar biliary obstruction was referred to our hospital. A diagnosis of gallbladder cancer was made from findings of a thickened gallbladder wall and massive ascites revealed by computed tomography (Fig. 1) and magnetic resonance cholangiopancreatography (Fig. 2). For biliary decompression and pathological confirmation, endoscopic retrograde cholangiography (ERC) was performed, and a 7-Fr plastic stent was placed (Fig. 3, Video 1).

The patient underwent a second ERC 4 days later because of elevated biliary enzymes. The plastic stent could not be removed using forceps and snares, and the torn-off stent was left in place (Fig. 4). Although needle-knife sphincterotomy was performed to expose the residual plastic stent, the stent could not be grasped. A 0.025-inch guidewire could be advanced alongside the plastic stent, but a sphincterotome (CleverCut 3V; Olympus, Tokyo, Japan) could not. Successful dilation of the perihilar biliary stricture was achieved by advancing a 6-Fr wire-guided diathermic dilator (Cysto-Gastro-Set; Endo-Flex GmbH, Voerde, Germany) (Fig. 5). However, the remaining plastic stent also migrated. Thus, a 10-mm lumen partially covered, self-expandable, metallic stent (WallFlex biliary stent; Boston Scientific Japan, Tokyo, Japan) was deployed alongside the plastic stent (Fig. 6). In cases of malignant biliary stricture, removal of a plastic stent is time-consuming and might cause complications. The
usefulness of a diathermic dilator for severe biliary strictures has been reported [1–5]. The use of diathermic dilation is also an effective rescue technique for unremovable occluded plastic stents.

Competing interests

None

The Authors

Ryo Sugiura1,2, Hiroshi Kawakami2,4, Nobuyuki Ehira1, Ichiro Iwanaga1, Minoru Uebayashi1, Masaki Kuwatanai, Naoya Sakamoto2
1 Department of Gastroenterology, Japanese Red Cross Kitami Hospital, Kitami, Japan
2 Department of Gastroenterology and Hepatology, Hokkaido University Hospital, Sapporo, Japan
3 Department of Gastroenterology and Hepatology, University of Miyazaki, Miyazaki, Japan
4 Center for Digestive Disease, University of Miyazaki Hospital, Miyazaki, Japan
5 Division of Endoscopy, Hokkaido University Hospital, Sapporo, Japan

Corresponding author

Hiroshi Kawakami, MD, PhD
Department of Gastroenterology and Hepatology, University of Miyazaki, Center for Digestive Disease, 5200, Kihara, Kiyotake-cho, 889-1692 Miyazaki, Japan
Fax: +81-985-859802
hiropon@med.miyazaki-u.ac.jp
Acknowledgment

We express our deepest appreciation to Dr. Yunosuke Takishin, Kazuharu Suzuki, and Naoki Kawagishi (Department of Gastroenterology, Japanese Red Cross Kitami Hospital) for clinical advice.

▶ Fig. 4 Endoscopic images. a Snaring of the plastic stent after precut sphincterotomy with a needle-knife. b The torn-off plastic stent was left in place.

▶ Fig. 5 Radiographic images. a A 0.025-inch guidewire was advanced alongside the plastic stent (inset: endoscopic view). b, c A 6-Fr diathermic dilator was advanced alongside the perihilar biliary stricture (inset: endoscopic view).
References


Bibliography

DOI http://dx.doi.org/10.1055/s-0042-121010
Endoscopy 2017; 49: E42–E45
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Fig. 6 Radiographic images showing the partially covered, self-expandable, metallic stent placed over the stricture alongside the plastic stent.