A rare complication of endoscopic retrograde cholangiopancreaticography is the entrapment of a Dormia basket during extraction of an impacted stone. The basket is usually retrieved after mechanical, shock-wave or laser lithotripsy. Open or laparoscopic surgery is rarely required [1].

We report our experience with a 74-year-old male patient who presented with cholangitis 6 years after laparoscopic cholecystectomy. Endoscopic retrograde cholangiography identified Vater’s papilla in a large duodenal diverticulum. After failure of papillary cannulation, needle-knife papillotomy was attempted but was abandoned due to hemorrhage. On a second attempt, 2 days later, we successfully performed a wide sphincterotomy. Cholangiography revealed an impacted common bile duct stone (Figure 1). A Dormia basket without lithotriptor capabilities (GC Medical, Athens, Greece) was selected because of its lower cost. Unfortunately, this became lodged around the firmly impacted stone. After cutting the basket’s wire we introduced a 3.2-mm disposable mechanical lithotriptor (Olympus Optical Co., Tokyo, Japan) but this failed to break up the stone due to entanglement of the wires and also became trapped. When attempting to remove it, the side-viewing single-lumen Olympus duodenoscope was accidentally inserted into the common bile duct and became firmly trapped. All attempts at dislodging the endoscope were unfruitful. The patient was then intubated and transferred to the operating room. Using a Kocher incision, a vertical cholecdochotomy was performed. The mechanical lithotriptor, the endoscope (Figure 2), the stone, and the basket were removed. A T tube (no. 6) was inserted and the patient made an uncomplicated recovery.

Impaction or entrapment of the basket occurs in about 6% of endoscopic retrograde cholangiopancreaticography procedures performed for cholelithiasis [2]. Dormia baskets with lithotriptor capabilities do not preclude basket entrapment but they do decrease the possibility of this occurring. When the basket becomes entrapped it can be removed either endoscopically or laparoscopically [1–3], but there have been no previous reports on the management of endoscope entrapment.

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