Intestinal bowel perforation and bacterial peritonitis secondary to migrated biliary and pancreatic stents

Case report

Intestinal bowel perforation by migrated biliary or pancreatic stent is a rare complication that can occur anywhere in the gastrointestinal tract [1–5]. We report two patients with intestinal perforation and bacterial peritonitis secondary to a migrated stent from the common bile duct and pancreatic duct.

A 43-year-old male with chronic pancreatitis, who underwent an endoscopic cystogastrostomy for a pseudocyst and stenting of the pancreatic duct, was transferred to our institution for treatment of bacterial peritonitis with Streptococcus sp. On admission he was febrile, hypotensive, and had a painful distended abdomen. Blood test revealed leukocytosis and cholestasis. Abdominal computed tomography (CT) scan showed ascites, intra-abdominal free air, and pancreatic calcifications.

The first patient was admitted after peritonitis secondary to migrated biliary and pancreatic stents. A CT scan showed ascites, intra-abdominal free air, and pancreatic calcifications. The patient had a painful abdomen.

Treatment consisted of endoscopic removal of the perforating stent and pigtail stents, percutaneous drainage of purulent ascites, intravenous antibiotics, bowel rest, and parenteral feeding. The patient recovered fully and was discharged from the hospital 14 days later.

The second case was that of a 71-year-old female patient with peritoneal dialysis, who underwent endoscopic retrograde cholangiopancreatography (ERCP) with biliary stenting for obstructive cholangitis. The patient developed septic shock, the biliary stent was surgically removed and primary repair of the ileal perforation was performed. The patient is still recovering.

The possibility of intestinal bowel perforation secondary to migrated biliary or pancreatic stent should be considered in patients presenting with abdominal pain after ERCP placement of stents. The choice between surgical vs. conservative management should be individualized and depends on the size and site of the perforation and any co-morbidity in the patient [2,5].

Endoscopy_UCTN_Code_CPL_1AK_2AD

T. C. Seeren1, T. G. Moreels1, R. A. Salgado2, S. M. Francque1, P. P. Michielsen1, P. M. Parizel1, P. A. Pelckmans1
1 Division of Gastroenterology and Hepatology, Antwerp University Hospital, Antwerp, Belgium
2 Division of Radiology, Antwerp University Hospital, Antwerp, Belgium

References


Bibliography

Endoscopy 2008; 40: E25
© Georg Thieme Verlag KG Stuttgart - New York - ISSN 0013-726X

Corresponding author
T. G. Moreels, MD, PhD
Division of Gastroenterology and Hepatology
Antwerp University Hospital
Wittekerkestraat 10
2650 Antwerp
Belgium
Fax: +32-3-8214478
tom.moreels@uza.be