A case of colonic perforation from biliary stent

A 57-year-old lady was referred 3 days after a laparoscopic cholecystectomy with right hypochondrial pain. Blood tests revealed leukocytosis, normal bilirubin but slightly raised alkaline phosphatase, alanine transaminase, and gamma glutamyl transferase. Ultrasonography and computed tomography (CT) scan of the abdomen demonstrated a right subphrenic fluid collection, and magnetic resonance cholangiopancreatography (MRCP) suggested a retained stone in the common bile duct (Fig. 1). A laparoscopic wash out and drainage was performed, draining 500 mL of bile, which ameliorated her symptoms. An endoscopic retrograde cholangiopancreatography (ERCP) demonstrated small cystic duct leak but no retained stone. So a polyethylene 10–Fr 7 cm long biliary endoprosthesis (Cotton/C177Leung, Wilson-Cook Medical Inc., Winston-Salem, North Carolina, USA) was inserted. Her condition improved, bile leak stopped, abdominal drain was removed, and she was discharged from hospital.

She re-presented 4 weeks later with a 3-day history of abdominal pain and no bowel movement. She was pyrexial and had peritonism in the lower abdomen. The biliary stent was seen to be present in the lower abdomen on abdominal radiograph (Fig. 2). Laparotomy revealed perforated stent through a sigmoid diverticulum with minimal contamination (Fig. 3). The stent was removed and the perforation was closed with a covering loop transverse colostomy. Her postoperative recovery was unremarkable, and 2 months later she underwent an uneventful sigmoid colectomy and closure of the colostomy.

Only nine other cases of colonic perforation (five free perforation in the peritoneum, one through the cecal diverticulum with localised abscess, and three to the adjacent organ or fistulating through the skin) have been reported [2–5]. (Not all references cited due to lack of space.) Stent perforation should be considered in a patient presenting with abdominal pain and peritonism following placement of a biliary endoprosthesis. Stents should always be removed following an exchange procedure to prevent risk of perforation.

References
5 Baty V, Denis B, Bigard MA, Gaucher P. Sigmoid diverticular perforation relating to the migration of polyethylene endoprosthesis. Endoscopy 1996; 28: 781

Bibliography
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