Abstract

Background and Objectives: Endoscopic retrograde cholangiopancreatography (ERCP) is still the most preferred method in Indonesia for patients with malignant obstructive jaundice. The role of therapeutic intervention endoscopic ultrasound (EUS) is still debatable regarding cost, availability, and hospital investment.

Methods: Therapeutic intervention EUS cases were reviewed from our EUS hospital database within 2 years period. The EUS equipment was an Olympus JF UCT 180 EUS scope which was connected to an Aloka IPF-1701C ultrasound machine (Tokyo, Japan).

Results: Of six patients who underwent therapeutic intervention EUS procedures, a 67-year-old male was referred with biliary obstruction due to duodenal malignancy with previous history of Billroth II operation. The papilla is placed at the duodenal bulb. Previous ERCP using the forward viewing scope was failed to attempt cannulation because of altered papilla due to advanced tumor. EUS-guided biliary drainage was then performed without any difficulty and a lumen-apposing metal stent (Hanaro stent) is placed from the duodenal bulb wall to the common bile duct. During follow-up, there was cholangitis complication which can be managed by antibiotic treatment. The bilirubin level went down within few days.

Conclusion: EUS-guided biliary drainage case example has shown a high impact in gastroenterology practice in Indonesia which represents the biggest Southeast Asian country. However, the need of training curriculum has to be considered despite the cost and hospital investment.

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P-THER-23

Maneuver of rendezvous and drainage of biliary track obstructed by papillary tumor

L. Arango, C. DIAZ
Caldas University, Manizales, Colombia

We present the drainage of the biliary tract in a 75-year-old patient with a papillary tumor. In her, it was impossible to perform endoscopic retrograde cholangiopancreatography (ERCP).

Steps are as given below:
1. After trying to perform ERCP and cannot do it, we change the duodenoscope by a Fujinon linear endosonograph;
2. We evaluate the dilated biliary track and from the gastric antrum. We achieve puncture the biliary track. The puncture is made with a Boston scientific needle 19-gauge;
3. Then, bilis is sucked and we inject a medium of contrast, to see anatomy;
4. Once the anatomy is checked, a hydrophilic guide of 0.035 mm was passed, with special handling directed to the duodenum;
5. At this time, we remove the lineal endosonograph and pass a duodenoscope of side vision. We grasp the hydrophilic guide

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P-THER-21

Transluminal derivation of the biliary tract, obstructed by tumor: Coledocoduodenostomy guided by endoscopic ultrasound

L. Arango, C. Diaz
Advanced Endoscopy University of Caldas, Union of Surgeons, Manizales, Caldas, Colombia

We present the technique of transluminal coledocoduodenostomy for a distal tumoral injury of biliary tract and pancreas that was not permitted to perform CPRE.

Our technique by steps is shown in the video, explaining with drawings and video which is performed.

Steps:
1. Place the linear endosonograph in DI;
2. Locate the distal point dilated from the coledoco;
3. We do Doppler to discover vessels that interpong between the transducer and the biliary tract;
4. We make a puncture in this case with Boston Scientific needle 19-gauge;
5. After the biliary puncture, we suck to check that there is bilis;
6. Contrasting to draw the biliary route in its entirety and planning the type of stent;
7. We introduce a hydrophilic 0.035 Terumo guide;
8. Through this, we pass a cystotomy of W. Cook 6 Fr;
9. In this way, we dilate the tract between the duodenum lumen and the biliary tract;
10. Then, we pass a self-expandable covered stent, size of variable size according to the need;
11. Should leave four combined-modality therapy stents in the duodenal lumen, to avoid migration as possible;
12. At the end, we infect contrast with a CPRE occlusion balloon to verify the waterproofing of the stent.

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P-THER-22

Therapeutic intervention endoscopic ultrasound in a patient with malignant biliary obstruction post-Billroth II operation
Abstract

with a snare and introduce it into the duodenoscope, passing through it a papilotome. Then, we perform a conventional ERCP with a self-expandable stent.

Evolution was satisfactory

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P- THER-24

Endoscopic ultrasound-guided biliary drainage in an operated case of right extended hepatectomy with secondaries causing hilar obstruction

Pankaj Desai

Surat Institute of Digestive Sciences, Surat, Gujarat, India

A 55-year-old male patient presented with complaints of increasing jaundice with itching and low-grade fever. He had undergone right extended hepatectomy 6 months back for right lobe hepatocellular carcinoma. Investigations revealed a total count of 9200/cumm, a bilirubin level of 18.6 mg/dl, and serum glutamic-pyruvic transaminase of 72 IU/L. Ultrasonography done revealed multiple para-aortic nodes and dilated left duct and intrahepatic biliary radical (IHBR). Computed tomography (CT) scan revealed multiple nodes at the area of the original confluence pressing of the left duct with dilatation of the left duct and IHBR. CT revealed a bowel loop near the hilum suggestive of end of jejunum to side of the left duct anastomosis with a tight narrowing at that level. We planned to palliate the patient with an endoscopic ultrasound (EUS)-guided hepaticogastrostomy. EUS was attempted with an intent to do a left duct drainage into the stomach with a Giobor stent. B3 radicle was carefully selected and puncture was made with a 19-gauge needle. The contrast did not go beyond the hilum. A Terumo guide wire was introduced and luckily the wire went into the distal common bile duct. This suggested that the hepaticojejunostomy was done end to side to the hilum. Hence, we now got the wire out of the papilla and performed a rendezvous procedure draining the left duct in the duodenum as this is much safer procedure than a hepaticogastrostomy. The patient was kept nil orally for 6 h and then on liquids for 24 h and diet started.

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