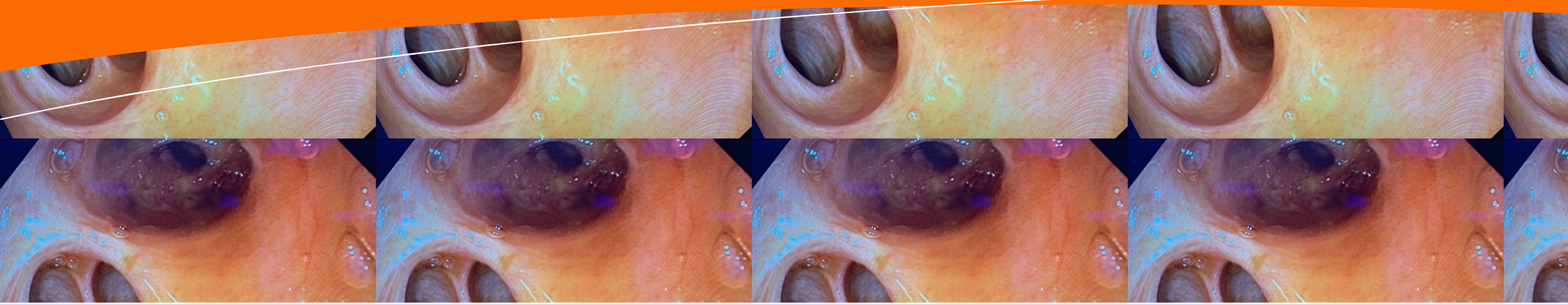
Gastroscopic cholangioscopy through accidental choledochoduodenostomy after percutaneous transhepatic cholangiography in a patient with disseminated pancreatic cancer.

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Introduction

In malignant obstructive jaundice the golden standard is Endoscopic retrograde cholangiopancreatography
(ERCP) with high technical success and fewest adverse events. When the procedure is not possible on unsuccessful alternatives include percutaneous transhepatic cholangiography (PTC) , surgical bypass or Endoscopic ultrasonography-guided choledochoduodenostomy (EUS-CD). In our center PTC is first choice after ERCP. PTC is associated with a higher degree of complications than both ERCP and EUS, including cholangitis, perforation, bleeding, pneumothorax and fistulation.

In this case we rapport a rare case of accidental choledochoduodenostomy.



Case description

62 year old female presents with 14 days of upper abdominalia and jaundice. Ultrasound reveal double duct sign and cholecystolithiasis. Bilirubin 92 umol/l. CT showed a 18 mm malignant tumor of caput pancreatis. Biopsy with adenocarcinoma. Whipples procedure was planed but peroperative the patient was non-resectable because of involvement of the inferior vena cava. ERCP was planned but unsuccessful and PTC was performed with great difficulty due to several via falsa. Finally a fully covered 10x100 mm SEMS was placed and patient started chemotherapy.

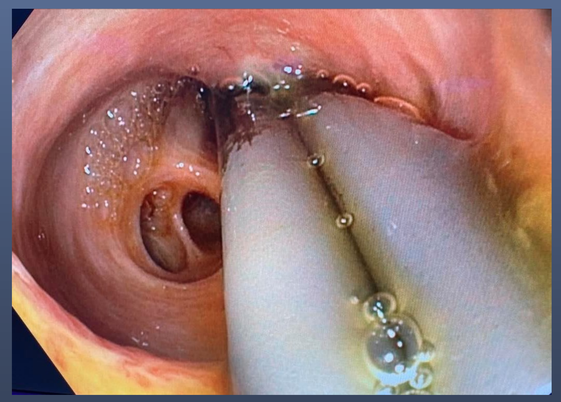
During the next few month there were progression of the disease with pulmonary metastasis and carcinomatosis. Due to stent occlusion, vomiting and obstruction iSn the second part of duodenum due to tumor on CT scan, a ERCP was performed. After removing the stent a choledochoduodenostomy was visualized in bulbus duodenum in tumorous tissue. The opening was 12 mm I diameter and direct cholangiography was performed with a gastroscope to the level of the bifurcation showing intrahepatic dilation but no obstruction. The 7 cm tumor occlution in the duodenum were handled with a 22x120 mm uncovered SEMS allowing passage from the choledochoduodenostomy through the SEMS

Discussion

Fistula formation after PTC is well described as biliobronchial fistula, cutaneobiliary fistula or bile-blood fistula. Duodenobiliary fistulas is also describe as a complication to cholecystolithiasis, ulcer and tumor.

Our patient presumably had a PTC guidewire penetrating the pancreatic tumor and exiting the duodenal bulb, and the SEMS thereby creating a choledochoduodenostomy.

This case rapport describes a rare and interesting case of accidental choledochoduodenal fistula as a complication to PTC demonstrating high resolution pictures from direct cholangiography using gastroscope.



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