LAPAROSCOPIC-ASSISTED AND TRANS-GASTRIC RENDEZVOUS IN A PATIENT WITH ALTERED INTESTINAL ANATOMY BY ROUX-EN-Y BYPASS (RYGBP): A CASE REPORT OF INSTITUTIONAL EXPERIENCE.

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INTRODUCTION

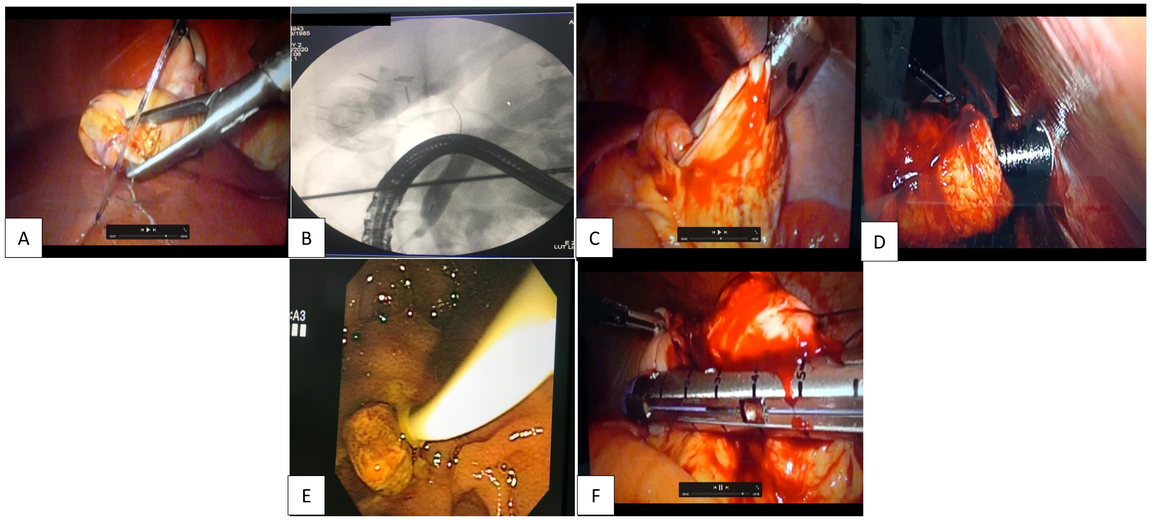
In recent years, the management of choledolithiasis in altered bowel anatomy's patients had led the development of different approaches for realize an endoscopic-retrograde cholangiopancreatography (ERCP) with the use of laparoscopic, enteroscopic or interventionist radiologic pathways(1,2). Additionally, is controversial the practice of prophylactic cholecystectomy for avoidance biliary diseases. In a recent systematic review(3), authors observed that biliary complications next to bariatric surgery had low incidence rate but the cholecystectomy at time of bariatric surgery was associated with an increasing risk of postoperative complications and increasing intervention time, they suggested to avoid this practice. Exists scarce data about the management of biliary complications in patients with previous gastric bypass with gallbladder treated in single operative time, we found just a case report of a woman treated with an endoscopic trans-gastric ERCP approach with a cholecystectomy at the same time with good results(4).

OBJECTIVE

Performing a case report of a patient with biliary pathology treated between gastroenterology and surgery services by contribute to increasing the literature availability about this topic.

CASE REPORT

We perform a case of a 34 years-old woman with medical history of RYGBP two years earlier for obesity that presented with upper abdominal pain than worse in postprandial period and vomiting, abdominal examination revealed upper right quadrant pain and positive murphy's sign, laboratory test showed normal blood count, aspartate aminotransferase 1416U/L (normal 14-36U/L), alanine aminotransferase 900U/L (<35U/L), total bilirubin 1,79mg/dL (0,2-1,4mg/dL), direct bilirubin 1,21mg/dL (0,0-0,3mg/dL), indirect bilirubin 0,58mg/dL (0,0-1,1mg/dL), alkaline phosphatase 371U/L (38-126U/L); abdominal ultrasonography suggestive signs of cholelithiasis and cholecystitis with increased bile duct diameter (8mm) and the magnetic nuclear cholangio-resonance showed a 6.6 mm calculi in bile duct.



A laparoscopic cholecystectomy was performed (A), next a cholangiography was realized with a catheter through the cystic duct with detection of two calculi in common bile duct (B), the excluded stomach was fixed with a suture purse and an incision was made in anterior wall (C), a 15mm trocar was introduced through gastrostomy and next a duodenoscopy across the trocar until reaching the papilla (D), the common biliary duct was selectively cannulated by a sphincterotome. The fluoroscope revealed two filling defects, the calculi were extracted with a balloon catheter (E), the gastrostomy was closed with mechanical suture (F). At the next day bilirubins descends, two days later the patient was discharged. Our patient had good outcomes, further studies are required to establish the safety and efficacy of rendezvous in these patients.

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