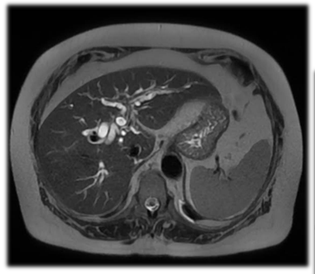
INTERVENTIONAL ENDOSCOPY IN THE MANAGEMENT OF DUODENAL PERFORATION CAUSED BY MIGRATED BILIARY STENT. A CASE REPORT

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Keywords: Interventional endoscopy, biliary stent, duodenal perforation.

INTRODUCTION

Gastrointestinal endoscopic perforations are complications with high morbidity and mortality rate requiring early intervention.

In the recent decades, there has been an increase in these complications proportional to the number of endoscopic procedures performed. Interventional endoscopy provides prompt correction of these defects, preventing extraluminal leakage of gastrointestinal contents and avoiding the need for surgery, which comes with increased costs, risks of complications and hospitalization days.





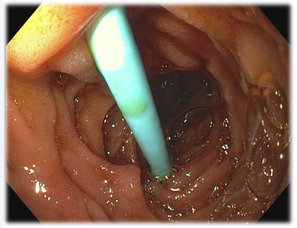
CASE DESCRIPTION

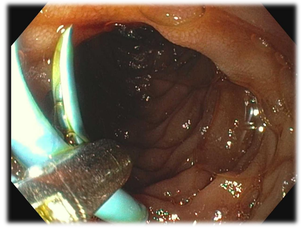
A 68-year-old woman came to the emergency department with a three-week history of intermittent abdominal pain in the epigastric and right hypochondriac regions (rated 6/10 on the pain scale), nausea and jaundice of the skin and mucous membranes. A magnetic resonance cholangiography (MRC) was performed revealing an enlarged gallbladder with multiple filling defects suggestive of gallstones.

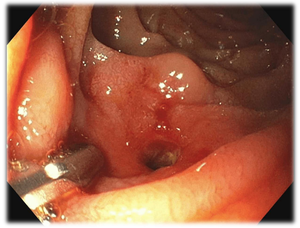
An endoscopic retrograde cholangiopancreatography (ERCP) was performed without eventualities, revealing an ampulla of Vater with normal morphology, but no bile outflow. The common bile duct was cannulated and opacified, showing a dilated intrahepatic bile duct secondary to a lack of contrast uptake in the common hepatic duct two centimeters below the bifurcation, suggestive of a Bismuth-Corlette Type I cholangiocarcinoma. A 7Fr x 10cm plastic biliary stent was placed ensuring biliary tract patency.

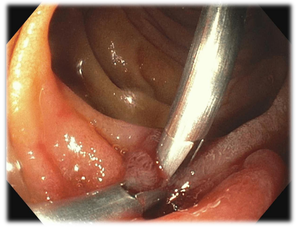
TB 13.1 mg/dl	DB 11.3 mg/dl	IB 1.68 mg/dl	ALT 191 U/L
ALP 256 U/L	GGT 510 U/L	AST 167 U/L	Lipase 63 U/L

26 hours later, the patient developed sinus bradycardia (47 bpm), retching and worsening epigastric pain. Blood tests for acute coronary syndrome and pancreatitis were negative. An abdominal CT was performed revealing periduodenal inflammation with free fluid at this level. We proceeded with an endoscopy which revealed partial migration of the plastic biliary stent towards the third portion of the duodenum creating a microperforation. The stent was repositioned with the assistance of foreign body forceps and closure of the microperforation was achieved using three hemostatic clips. Antibiotic therapy with coverage for intraabdominal agents was administered.











CONCLUSION

This patient had a satisfactory evolution and a good clinical response, thus avoiding the need of surgery because of endoscopic intervention; a much safer, cost effective procedure with reduced postoperative morbidity.