

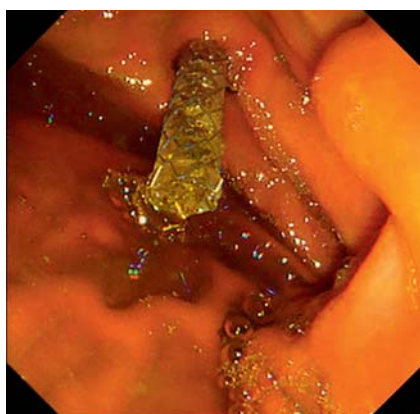
Endoscopic ultrasound (EUS)-guided antegrade intervention for a hepaticojejunostomy anastomosis obstruction under peroral cholangioscopy via an EUS-guided hepaticogastrostomy route



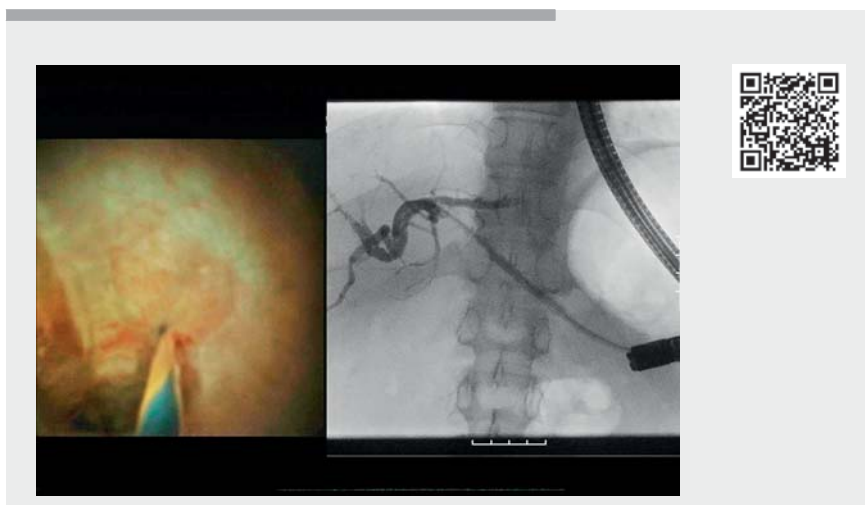
► **Fig. 1** Computed tomography image showing the dilated intrahepatic bile duct (arrow).



► **Fig. 2** During fluoroscopy, no contrast medium flowed out of the dilated bile duct (arrow).



► **Fig. 3** A 6-mm, fully covered, self-expandable metal stent was inserted across the endoscopic ultrasound-guided hepaticogastrostomy route.



► **Video 1** Endoscopic ultrasound (EUS)-guided antegrade intervention for complete obstruction of a hepaticojejunostomy anastomosis under peroral cholangioscopy via an EUS-guided hepaticogastrostomy route.

A 47-year-old man who had undergone subtotal stomach-preserving pancreaticoduodenectomy presented with recurrent cholangitis, possibly due to a hepaticojejunostomy anastomosis (HJA) stricture (► **Fig. 1**). Endoscopic retrograde cholangiopancreatography using short-type single-balloon endoscopy was planned. However, as the HJA was completely occluded by a fibrous membrane, we could not insert the cannula into the bile duct. Therefore, we performed endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS).

The dilated intrahepatic bile duct (B3) was punctured with a 19-gauge needle (EZ shot 3 plus; Olympus Co., Tokyo, Japan). However, no contrast medium flowed from the dilated bile duct to the jejunum, and a 0.025-inch guidewire could not be inserted across the anastomosis (► **Fig. 2**).

One month after EUS-HGS, a 7-Fr plastic stent was exchanged for a 6-mm, fully covered, self-expandable metal stent

(HANAROSTENT Biliary; M.I. Tech, Gyeonggi-do, Korea) across the EUS-HGS route (► **Fig. 3**). A SpyGlass DS system (Boston Scientific Corp., Marlborough, Massachusetts, USA) was used to perform cholangioscopy to visualize the anastomosis from the inside of the bile duct (► **Video 1**). We found that the duct was completely obstructed at the anastomotic site and covered with a fibrous membrane (► **Fig. 4a**). It was difficult to break through this obstruction even with cholangioscopy guidance. Repeated poking with a stiff edge of a guidewire partially broke the fibrous membrane, and a guidewire could finally be passed through the anastomosis; however, a 4-Fr catheter could not be passed through the anastomosis. We dilated the anastomosis stricture by gradually removing the fibrotic tissue using biopsy forceps (SpyBite MAX; Boston Scientific Corp.) under direct cholangioscopic observation (► **Fig. 4b**). After dilation of the anastomosis using a 7-Fr catheter and a



► **Fig. 4** Cholangioscopy and fluoroscopy images. **a** Cholangioscopic image showing the completely obstructed bile duct at the anastomotic site covered with fibrous membrane (arrowheads). **b** Biopsy forceps were used to remove the fibrotic tissue before dilation of the anastomosis under direct cholangioscopic observation.

6-mm balloon catheter, antegrade trans-anastomotic placement of a 7-Fr plastic stent across the EUS-HGS route was performed. No procedure-related adverse events were observed, and cholangitis improved after treatment.

Although EUS-guided drainage for stenosis of the HJA has been reported [1], complete obstruction makes it difficult to recanalize the anastomosis using endoscopic procedures. Recently, the usefulness of cholangioscopy through a percutaneous transhepatic or transpapillary route for postoperative biliary strictures or obstructions has been described [2,3]. EUS-guided antegrade intervention under cholangioscopy via an EUS-HGS route is an alternative treatment.

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Competing interests

The authors declare that they have no conflict of interest.

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References

- [1] James TW, Fan YC, Baron TH. EUS-guided hepaticoenterostomy as a portal to allow definitive antegrade treatment of benign biliary disease in patients with surgically altered anatomy. *Gastrointest Endosc* 2018; 88: 547–554
- [2] Fujii Y, Koshita S, Ito K. Percutaneous transhepatic cholangioscopy using SpyGlass DS for an anastomotic stenosis after choledochojunostomy. *Dig Endosc* 2018; 30: 806–807
- [3] Yane K, Ihara H, Sumiyoshi T et al. Successful recanalization of complete bile duct obstruction using piercing technique under cholangioscopic guidance. *Endoscopy* 2021. doi:10.1055/a-1540-6735

Bibliography

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