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Choledocholithiasis in a patient carrying an intragastric balloon. Removal or direct ERCP?

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Dear Editor,

Endoscopic retrograde cholangiopancreatography (ERCP) is a diagnostic, therapeutic technique for the management of pancreato-biliary conditions. Technical contraindications include the presence of intraluminal foreign bodies precluding endoscope passage.1,2,3

Intragastric balloon (IGB) is a bariatric procedure that provides sensations of early fullness and satiety from intragastric occupation, thus leading to weight loss. While, according to guidelines, choledocholithiasis and cholangitis do not represent an indication for IGB removal in contrast to moderate-severe pancreatitis, where need for an ERCP and the procedure’s technical difficulty most commonly require it.3,4

We report the case of a female patient with an IGB where ERCP was indicated.

CASE REPORT:

A 47-year-old woman visited the emergency room for epigastric abdominal pain radiating to her back. She had jaundice without pyrexic symptoms. At the ER an ultrasonogram revealed choledolithiasis and a dilated common bile duct (11 mm in diameter), no cause being then identified. Lab tests rule out pancreatic involvement and associated infection. The patient had an IGB (Photo 1a) implanted 5 months before the present episode.

She was admitted to the gastroenterology ward with choledocholithiasis as suspected diagnosis. The study was completed by endoscopic ultrasound (EUS), which confirmed a dilated hepatocholedochal duct at 15.3 mm in diameter (Photo 1b), secondary to multiple choledochal stones.

A direct ERCP procedure was initiated where the IGB precluded rectification and proper placement, which forced the use of a double-guidewire technique for cannulation (Photo 1c). Sphincterotomy and sphincteroplasty to 10 mm ensued, and 8 stones were removed using a balloon and then a basket catheter (Photo 1d). The patient was discharged at 24 hours after the procedure with no complications.
DISCUSSION:

No prior studies are available that describe the possibility of therapeutic ERCP for choledocholithiasis in IGB-carrying patients; in most cases IGB removal is taken for granted because of the procedure’s technical difficulty.

Our case report may well show a safe alternative to IGB removal by using less conventional cannulation techniques without higher complication rates. However, further cases are needed in order to draw significant conclusions regarding their widespread use.

REFERENCES

Figure 1: Images obtained from the patient. Photo 1a: endoscopic image where the IGB may be identified in the gastric body. Photo 1b: EUS image with measurement of common bile duct diameter and intraductal stones. Photo 1c: the “double-guidewire” technique for cannulation of the biliary tract. Photo 1d: removal of two large stones after sphincterotomy and sphincteroplasty.