Revista Española de Enfermedades Digestivas
The Spanish Journal of Gastroenterology

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DOI: 10.17235/reed.2024.10222/2023
Link: PubMed (Epub ahead of print)

Please cite this article as:
García-Cano Jesús, Viñuelas Chicano Miriam, Valiente González Laura. Endoscopic drainage of malignant distal biliary obstruction. Will endoscopic retrograde cholangiopancreatography no longer be necessary?. Rev Esp Enferm Dig 2024. doi: 10.17235/reed.2024.10222/2023.

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CC 10222

Endoscopic drainage of malignant distal biliary obstruction. Will endoscopic retrograde cholangiopancreatography no longer be necessary?

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Conflict of interest: the authors declare no conflict of interest.

Artificial intelligence: the authors declare that they did not use artificial intelligence (AI) or any AI-assisted technologies in the elaboration of the article.

Keywords: Obstructive jaundice. Endoscopic drainage. ERCP. EUS.

Dear Editor,

We read with interest the editorial by Vila et al. (1) on the paradigm shift for endoscopic biliary drainage of malignant distal biliary obstruction (MDBO), which places endoscopic ultrasound (EUS) drainage as the first option instead of traditional endoscopic retrograde cholangiopancreatography (ERCP) drainage. Since the beginning of therapeutic ERCP 50 years ago, this type of obstruction has been the easiest to drain since only one stent is required. It is well known that biliary cannulation of the papilla of Vater due to tumor induced jaundice is sometimes difficult. Precutting techniques are often used, which increase the risk of complications (Fig. 1A). On other occasions, duodenal infiltration makes it impossible to advance the duodenoscope to the papilla or identify it (Fig. 1B). A failed ERCP produces a negative psychological impact on the endoscopist (2), the patient and their family. However, in many cases, effective drainage can be carried out by ERCP in a short procedure

performed without assuming risks (Fig. 1C and D). The modern biliary endoscopist must have the duodenoscope in one hand and the therapeutic echoendoscope in the other. ERCP training alone is no longer appropriate because the goal is to drain the obstruction during a single session. Thus, in more and more centers, the patient signs a single consent for endoscopic biliary drainage, whether by ERCP, EUS or combined (3).

Should EUS drainage be used first for MDBO without attempting ERCP? Many endoscopists still prefer drainage of the obstruction through the papilla as it is a more physiological route. Sometimes dysfunction occurs in the lateral drainage of the common bile duct provided by EUS choledochoduodenostomy (4). Furthermore, as noted in the editorial, one of the keys to success in EUS drainage is a common bile duct diameter of at least 15 mm (1), which may not occur in all cases.

A possible protocol for endoscopic drainage of MDBO could start with the duodenoscope for ERCP. If the papilla of Vater is accessible, cannulation can be attempted considering the ESGE criteria for a difficult cannulation (5): more than five contacts with the papilla; more than five minutes spent attempting to cannulate following visualization of the papilla; more than one unintended pancreatic duct cannulation or opacification. If biliary cannulation is not achieved, immediately switch to EUS drainage during the same session. Occasionally, the double guidewire technique or even transpancreatic biliary sphincterotomy can be used, but not needle-knife precut.

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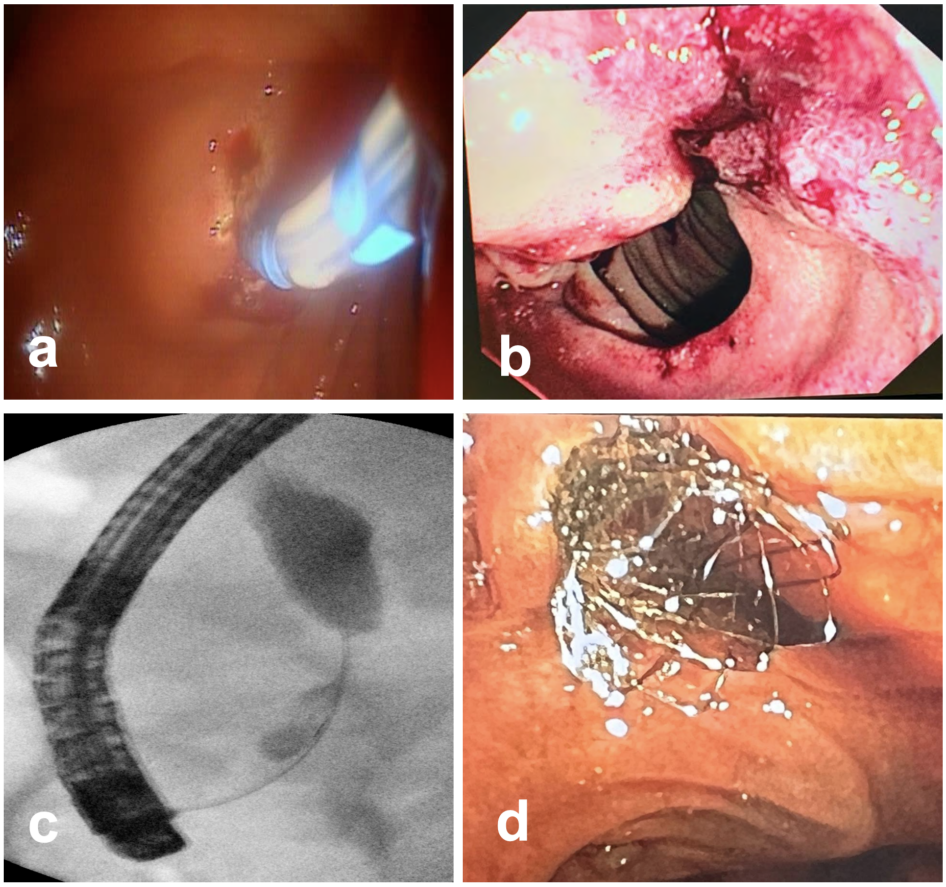

Fig. 1. Three different patients with obstructive jaundice secondary to cancer of the head of the pancreas. A. Needle-knife precut to achieve biliary cannulation. B. Duodenal infiltration that made it impossible to locate the papilla. C and D. Successful cannulation with standard techniques and stent placement carried out in a few minutes.