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Rescue with echoendoscopy-guided cholecystogastrostomy in a patient with rectal melanoma metastasis. A diagnostic and therapeutic challenge

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Dear Editor,

We present the case of a 70-year-old woman with a history of transanal resection of rectal melanoma who presented with obstructive jaundice, undergoing contrast-enhanced abdominal CT in which dilatation of the intrahepatic and extrahepatic biliary tract was observed, with abrupt amputation due to a lesion in the pancreatic uncinate process.

Echoendoscopy was performed, visualizing a heterogeneous solid LOE of 35 mm in diameter in the pancreatic head, which caused diffuse dilatation of the intra and extrahepatic bile duct with a 17 mm choledochus, and retrograde dilatation of the main pancreatic duct, with puncture from the duodenal bulb obtaining two cylinders compatible with biopsy of duodenal mucosa with melanoma infiltration.

Transpapillary drainage was attempted by ERCP, but failed due to duodenal infiltration that prevented identification of the papilla given the presence of blackish lesion and granular mucosa. Therefore, the possibility of palliative drainage of the biliary tract by cholecystogastrostomy or endoscopic choledocho-duoduodenostomy was considered as an alternative to external drainage, performing echoendoscopy without achieving

an adequate window from the bulb, finally opting for cholecystogastrostomy from the antrum with placement of a luminal positioning prosthesis (image 1), without incidents and with subsequent improvement of hyperbilirubinemia.

Discussion

The treatment of choice for drainage of the biliary tract in obstructive jaundice of tumor origin is ERCP, although this is not possible in up to 16% of cases. Drainage of the biliary tract by choledochoduodenostomy guided by echoendoscopy was first described in 2001 and although it is the most frequently used technique, there are cases such as the one described, in which a good vent from the bulb is not achieved due to interposition of structures. In these cases, cholecystogastrostomy guided by echoendoscopy is an effective and safe alternative (1). The easy access to the gallbladder from the gastrointestinal tract makes this technique very attractive, being useful not only in cases of obstructive jaundice of tumor origin but also in cases of complicated cholecystitis in patients with high surgical risk (2), for example. More comparative studies should be carried out to see the benefits of this technique and the characteristics of the patients in whom it is performed.

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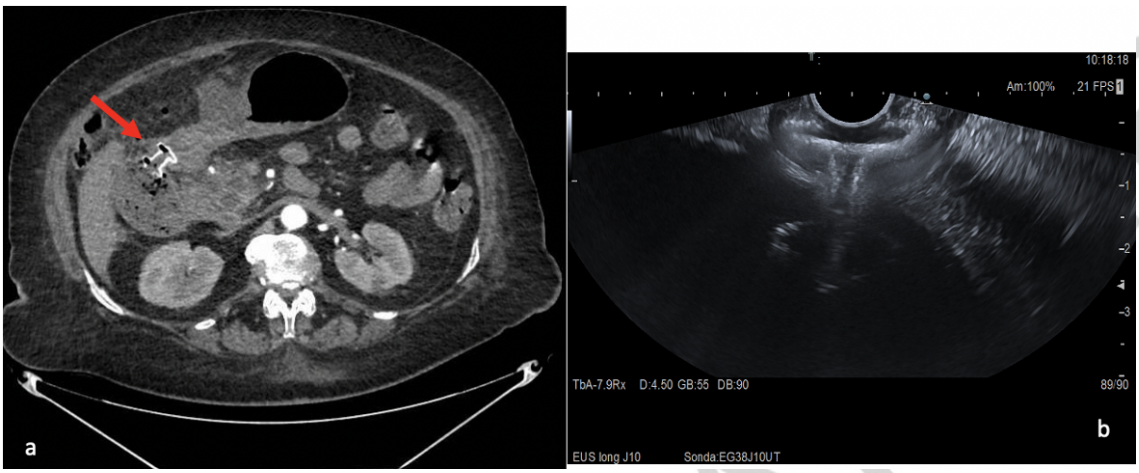

Fig. 1. a) Abdominal CT showing placement of a 10 mm diameter luminal seating prosthesis (arrow) from the gastric antrum. b) Echoendoscopic image of luminal seating prosthesis, with the gastric flap remaining in the antrum lateral to the pylorus.