

Bedside ERCP without fluoroscopy in a case with acute cholangitis and impaired general status

Genel durumu bozuk akut kolanjitli hastada floroskopisiz yatak başı ERCP

To the Editor,

Endoscopic biliary drainage is an effective method to achieve biliary decompression in the management of patients with acute cholangitis (1-3). We discuss herein bedside endoscopic biliary stent insertion without fluoroscopy in a case with acute cholangitis and impaired general status in the intensive care unit.

A 75-year-old male patient was admitted to the intensive care unit due to jaundice and unconsciousness. On admission, he had an impaired general status, was unconscious, and the skin and mucosa were severely icteric. Laboratory findings were as follows: serum alkaline phosphatase (ALP) 713 U/L (normal: 0–270 U/L); γ -glutamyl transpeptidase (GGT) 517 U/L (normal: 5–61 U/L); alanine transaminase (ALT) 92 U/L (normal: 0–41 U/L); aspartate transaminase (AST) 124 U/L (normal: 0–37 U/L); total and direct bilirubin 29.22 mg/dl (normal: 0.01–1.00 mg/dl) and 19.49 mg/dl (normal: 0.1–0.3 mg/dl), respectively; hematocrit 32% (normal for male, 40–49%); leukocyte count 12,800/uL (normal: 4000–12000/uL); platelet count 410,000/uL (130,000–400,000/uL); prothrombin time (PT) 23.2 sec (normal: 10–14 sec); activated partial thromboplastin time (aPTT) 28.1 sec (normal: 29–45 sec); and international normalized ratio (INR) 2.1 (normal: 1–1.3). Abdominal ultrasound showed that the intrahepatic biliary tract was dilated; the common bile duct was measured as 20 mm at its widest part and a calculus of 12.5 mm diameter was found distally. Since the patient had the pentad of acute cholangitis (pain, fever, jaundice, hypotension, and oliguria), the picture was considered as severe; therefore, we decided to perform emergency endoscopic biliary drainage. Since the patient could not be mobilized to the radiology unit due to his impaired status, it was planned that he would undergo a bedside endoscopic biliary drainage without fluoroscopy. A side-view duodenoscope was inserted. After locating the major

papilla, cannulation was performed with a standard catheter directed at the 11 o'clock position on the papilla or biliary axis with attempted deep cannulation of the bile duct. When the catheter was used for aspiration, bile flow confirmed correct cannulation of the common bile duct. The bile was observed to be dense and infected. We decided to insert a stent for biliary drainage. The papilla entrance was determined and a 7F Amsterdam type plastic stent, 8 cm in length and with lateral pores and flaps on both sides, was inserted. The next day, serum bilirubin level decreased. He was discharged as his general status had improved.

When compared with surgery under general anesthesia, the endoscopic retrograde cholangiopancreatography (ERCP) procedure has a lower mortality and morbidity (1-4). In routine practice, the ERCP procedure and biliary stenting are performed with fluoroscopy. However, in the intensive care unit, in patients with an impaired general status who cannot be transported to the endoscopy or radiology units and those with acute cholangitis for biliary obstruction, emergent bedside nasobiliary drainage (NBD) may be applied (1, 5-8). Although it would have been more adequate to do NBD to control bile drainage and to irrigate, it was thought that fixation of NBD would be difficult since the patient was agitated and unconscious; hence, NBD was abandoned. In addition, the patient was elderly and had severe comorbidities, so it was thought that stenting would provide both emergency endoscopic biliary drainage and prevent obstructive complications related with the calculi. Furthermore, stenting would not require a second ERCP for biliary drainage, while NBD would not remain too long after resolution of the cholangitis. In elderly people with such problems and where calculi cannot be extracted, biliary stenting is a treatment option. In the literature review, biliary

stenting without fluoroscopy, guided by ultrasound, has been reported as case reports, but no cases have been reported of biliary stent insertion without the guidance of any imaging method.

In conclusion, in patients with impaired general status and those unfavorable for transport to the

endoscopy room for ERCP, bedside NBD or stenting is beneficial if biliary decompression is obligatory. This case is original since, to our knowledge, there has been no other case report of bedside biliary stenting in the literature, and the procedure yields a successful result.

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Giant mesenteric cyst can present as pseudoascites with raised Ca125

Dev mezenterik kist, yüksek Ca125 ve asit yanılığı ile prezente olabilir

To the Editor,

A mesenteric cyst is one of the rarest abdominal tumors. Mesenteric cysts, with sizes varying from a few centimeters (cm) to more than 30 cm in diameter, may occur in the small bowel mesentery, the transverse mesocolon, and the root of the mesentery with retroperitoneal extension (1-3). The clinical presentation relates to the size, location, and complications, such as bowel obstruction, perforation, volvulus, or malignant degeneration. Presenting symptoms include abdominal distensi-

on, pain, and vomiting, often mimicking appendicitis or an acute abdomen (3, 4).

A 57-year-old female patient presented to our clinic with abdominal distension and pain. An examination revealed the presence of dullness and an extremely distended abdomen. The routine laboratory results were normal. The tumor marker results showed a high Ca125 concentration of 221.9 U/ml (0-35 U/ml).

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Manuscript received: 15.12.2008 **Accepted:** 08.07.2009

doi: 10.4318/tjg.2009.0037