Endoscopic sphincteroplasty: a novel and safe alternative to papillotomy in the management of bile duct stones

P Mac Mathuna, P White, E Clarke, J Lennon, J Crowe

Abstract
Removal of bile duct stones during endoscopic retrograde cholangiopancreatography (ERCP) usually includes papillotomy. Papillotomy is associated with occasional complications and in addition, the longterm sequelae of papillotomy in young patients having laparoscopic cholecystectomy remain unclear. As an alternative to papillotomy, this study prospectively evaluated the efficacy and safety of endoscopic balloon sphincteroplasty to facilitate bile duct clearance. Of 32 patients with bile duct stones (diameter 3–30 mm) at ERCP, sphincteroplasty was considered inappropriate in four patients because of stone size (>20 mm) necessitating papillotomy for bile duct clearance. Sphincteroplasty was performed in the remaining 28 patients to permit duct clearance by Dormier basket, balloon or mechanical lithotripsy. The bile duct was cleared in 22 patients (79%) while additional measures including papillotomy or stent insertion were required in the remaining six patients (21%) because of stone size or technical difficulties. There was no associated papillary haemorrhage. Pancreatitis was seen in one patient (4%) but resolved within 24 hours. Our preliminary experience suggests that sphincteroplasty is a safe and effective sphincter preservation technique that significantly reduces the necessity for papillotomy in the management of bile duct stones.

(Gut 1994; 35: 127–129)

Patients and methods
Thirty two consecutive patients with clinical and sonographic evidence of extrahepatic biliary obstruction had bile duct stones confirmed at ERCP. The mean age was 54 years with an age range of 25 to 84 including 26 female and six male patients. Seven patients had had cholecystectomy (four open and three laparoscopic). The mean number of bile duct stones was two (range 1–6) with a mean size of 8 mm (range 3 to 25 mm) (Table). Coagulation indices were normal and each patient received conventional antibiotic prophylaxis. ERCP was performed under intravenous sedation with midazolam 5–10 mg and pethidine 50–100 mg with some patients also receiving hyoscine 20–40 mg. Sphincteroplasty was considered inappropriate in four patients because of stone size (>20 mm) and a papillotomy was performed with successful bile duct clearance. Sphincteroplasty was carried out in the remaining 28 patients.

SPHINCTEROPLASTY TECHNIQUE
After diagnostic cholangiography at ERCP using an Olympus video duodenoscope with a 3-2 or 4-2 biopsy channel, a 0.21 guide wire (Accrex 21, Wilson-Cook) is passed through the diagnostic cannula into the bile duct. A Maxforce 5 French balloon tipped biliary catheter (Microvasive, Boston, USA) with a total length of 180 cm and balloon length of 2 cm is then passed over the guide wire, positioning the deflated balloon across the papilla. The correct position of the balloon is confirmed in two ways, firstly by endoscopic visualisation and secondly by the position of two radio-opaque markers at each end of the balloon on x-ray screening. The balloon is

Clinical details, stone characteristics, outcome, and complications of patients having balloon sphincteroplasty

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ERCP=endoscopic retrograde cholangiopancreatography.
then inflated with a 4 ml mixture of radio-opaque contrast medium and saline to a pressure of 8 atmospheres and to a maximum diameter of 1 cm for 60 seconds (Figure). After deflation for 30 seconds the balloon is re-inflated for 60 seconds. A central impression corresponding to the sphincter is visible during balloon inflation (Figure). The dilated papilla permits easy access to dormier basket, 'retrieval' balloon (Figure) or mechanical lithotripsy for extraction of the bile duct stones. Biliary manometry was not performed.

Results

The bile duct was cleared in 22 of 28 patients (79%) with sphincterplasty (Table). Stone size ranged from 3 to 20 mm and the maximum number of stones removed from a single patient was five. Mechanical lithotripsy was used in two patients to extract large stones of 15–20 mm in diameter. Two patients (7%) had a second ERCP (without repeat sphincterplasty) to achieve duct clearance. In one patient in whom sphincteroplasty was successful, the papilla was located within a large diverticulum. Transient discomfort was noted in about half of the patients during balloon inflation. No procedure related haemorrhage was seen but sphincteroplasty was complicated by pancreatitis in one patient (4%). This episode was associated with a maximum serum amylase of 6500 IU/l and resolved within 24 hours after intravenous fluids and analgesia.

Sphincteroplasty alone failed to clear the bile duct in six of 28 patients (21%) (Table). In four patients (14%), papillotomy was also required to extract stones up to 20 mm in diameter after unsuccessful basket retrieval with sphincteroplasty alone. As regards the two remaining patients (7%) in whom sphincteroplasty failed to clear the bile duct, a biliary prosthesis was inserted with satisfactory drainage. A large papillotomy was considered hazardous in these two patients who were elderly and debilitated with large bile duct stones in whom stone extraction was technically difficult despite a sphincteroplasty. Insertion of an endoprosthesis is now an accepted method of establishing biliary drainage in such patients. Median follow up of 16 weeks (range 2–44) for all 28 patients did not show any adverse effects associated with sphincteroplasty.

Discussion

Bile duct stones are reported to occur in about 15–18% of patients with gall bladder stones. In the absence of an effective method to clear the bile duct during laparoscopic cholecystectomy, the demand for ERCP will probably increase. Papillotomy, however, may be associated with complications. Apart from these immediate complications, concern regarding the long-term sequelae of papillotomy in young patients stimulated our interest in an alternative approach. Our results show that when balloon sphincteroplasty was used, papillotomy was unnecessary to facilitate bile duct clearance in most patients (79%). Stones were removed by dormier basket or balloon in most patients while mechanical lithotripsy was required for a few with large stones. It is notable that this series included a patient with the papilla located within a large diverticulum, a situation associated with a higher risk of perforation if papillotomy is performed. The procedure is not difficult to perform and requires less skill than papillotomy. In particular, no papillary haemorrhage was seen. There were no complications apart from a single case of pancreatitis, which settled on conservative management within 24 hours. To date, no longer term adverse effects have been reported in any of the patients. The effect of sphincteroplasty on papillary function has yet to be determined.

What are the limitations of sphincteroplasty? We decided on clinical grounds not to use this technique in four patients with stones more than 2 cm in size to avoid the prospect of impaction during basket retrieval. While large pigment 'soft' stones (>2 cm) may be crushed and subsequently removed after sphincteroplasty alone, the possibility of impaction with 'hard' stones with the attendant possible requirement for surgery must be borne in mind. Sphincteroplasty alone was unsuccessful in bile duct clearance in six patients (22%) in our series and this related primarily to technical difficulties in retrieving stones 15–20 mm in size.

The results show that balloon sphincteroplasty (with or without lithotripsy) is a safe and effective technique that significantly reduces the need for papillotomy in the management of bile duct stones. Although the longterm effect on papillary function is unclear, more widespread application of this sphincter preservation technique including manometric evaluation is warranted to confirm our preliminary encouraging results.

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