Combined percutaneous and endoscopic procedures for bile duct obstruction

Deep cannulation of the bile duct is essential for the successful treatment of biliary obstruction. Even the most experienced endoscopist cannot always achieve this. Identifiable causes of failure include previous gastric surgery and periampullary diverticulum, but often it is simply not possible to cannulate the bile duct selectively. Successful cannulation can be increased by using intravenous glucagon or sublingual trinitrin to relax the choledochal sphincter. A hydrophilic, polymer coated guidewire can negotiate a tortuous sphincter segment and a finely tapered cannula is useful where there is a very small papillary orifice. Needle knife papillotomy often works when all else fails.5

Tumours at any level in the bile duct system may be impossible to negotiate. Success rates can be improved by using a guidewire with a preformed curve. Hydrophilic polymer coated guidewires are particularly valuable, especially if used in conjunction with a stiff catheter such as a biliary dilator. These guidewires will slide through even the tightest, most tortuous stricture, which cannot be accessed by using a standard Teflon coated wire. Unilateral stent placement is adequate treatment for most1 patients with tumours of the hepatic ducts, but it may be better to place stents bilaterally.4 This can only be achieved in a few, although stiffer catheters, preformed guidewires, and hydrophilic guidewires all help. A percutaneous transhepatic approach can be useful when it proves impossible to negotiate an obstruction whether physiological, anatomical or pathological.

Percutaneous insertion of plastic stents for malignant bile duct obstruction has now largely been overtaken by the endoscopic approach. This is not only because of the wide availability of endoscopic retrograde cholangiopancreatography (ERCP), but mainly because of the higher complication rate of percutaneous stenting, which is related to the size of the transhepatic track necessary to undertake the procedure.5 Percutaneous transhepatic assistance for the endoscopist was initially described for the treatment of gall stone disease,6,7 but it was soon clear8 that it was possible to insert a 10 or 12 French stent endoscopically using a transhepatic guidewire provided by the radiologist who need only make a 5 or 6 Fr track through the liver.

Other studies have confirmed the value of the combined percutaneous and endoscopic procedure with success rates for stent placement approaching 100%.9 The complication rate, as would be expected, is higher than for endoscopic stent insertion and is intermediate between endoscopic and percutaneous palliative procedures. The main complication is cholangitis.

How soon should percutaneous transhepatic cholangiography (PTC) be performed after endoscopic stent insertion has failed? No data exist to answer this question unequivocally, but if an obstructed duct system has been contaminated with contrast medium injected during ERCP, then percutaneous biliary drainage should be provided as soon as possible, probably within 24 hours. Otherwise there is no urgency, but it is probably wise for the patient to continue receiving intravenous antibiotics and a careful check kept on fluid balance and renal function. Some advocate that when ERCP fails, PTC should be performed immediately, followed by repeat ERCP for completion of the combined procedure at the same time. This requires an extremely flexible ERCP list and a patient with a great deal of stamina. My own preferred option is to perform PTC and establish external drainage within 48 hours of failed ERCP and then to proceed to ERCP and stent insertion in the next 48 hours. In this way the patient is not submitted to prolonged, possibly uncomfortable procedures and a short period of external drainage is provided before attempts are made to negotiate the stricture. While many strictures can be negotiated at the time of the initial PTC, nearly all are negotiable after a short period of drainage, particularly if hydrophilic polymer coated wires, straight and angled torque control catheters are available. In addition, if there is possible bacterial contamination of the biliary system, drainage for a short period reduces the risk of severe cholangitis, which can occur if prolonged attempts are made to negotiate the stricture at the initial PTC. There is no published evidence yet to support a preference for either a one stage or a multiple stage combined procedure. A percutaneous external drainage catheter left in position for more than a week becomes an irritation and a frustration to the patient with increasing risk of infection of the catheter entry site, so that a multiple stage procedure should be expedited to minimise these problems. Prophylactic antibiotics, which should be started before the initial ERCP, should be continued until drainage is established. Mezlocillin or piperacillin seem best.10 Nevertheless, cholangitis will still...
occur despite antibiotics, but is usually mild and easily con-
trolled by adequate bile drainage or by a change in anti-
biotic treatment based on the results of culture.

Sedation and analgesia are essential during percutaneous pro-
cedures. While midazolam is effective sedation for ERCP, it is less successful for PTC, as the patient can become restless, particularly if the procedure causes dis-
comfort. I find a combination of lorazepam and droperidol
given orally about 90 minutes before the procedure together
with an intravenous opioid when the patient reaches the flouropsy table, gives excellent control.

Once the guidewire has been advanced and the duodenal
puncture site is chosen, a guidewire is used to monitor the patient's state throughout.

When using a combined procedure to deal with common
duct stones or tumours, a right duct approach is used for
the PTC. The fine 22G needle is best inserted in the ante-
rrior axillary line, angled a little dorsally towards the porta
hepatis. The puncture site should be as far cranially as
the costophrenic sulcus will permit and the needle tip should be
directed caudally to enter either segment 6 or 7 ducts to
provide a smooth curve without sharp angulation for the
approach to the common duct. If a left duct approach is
necessary, then puncture of the anterior segmental duct
(segment 3) in the left lobe should be undertaken peripher-
ally to provide a stable long transhepatic approach to a left hepatic duct lesion. Selection of a duct for puncture is best
made using ultrasound guidance, particularly when
approaching the left duct system. Having gained access to
the bile duct with a sheathed needle large enough to take a
0-035 inch guidewire, it is worthwhile decompressing the
duct system before exchanging the sheath for a drainage
catheter over the guidewire. If the duct system is not
decompressed, bile will leak into the peritoneum during
catheter exchange, often causing considerable discomfort
to the patient.

Once the obstructing lesion and the papilla have been
negotiated, and a guidewire and catheter placed in the
duodenum, the endoscopist using an endoscope with a
biopsy channel large enough to take at least a 10 Fr stent,
can grasp the tip of a 450 cm guidewire using a stone
evacuation basket or grasping forceps. The guidewire should
be grasped at least 3 cm from the tip of its floppy end so
that the wire doubles as it is withdrawn up the channel
of the endoscope. This reduces the risk of damage to the
endoscope biopsy channel. The guidewire should be fed
into the percutaneous catheter by an assistant, while a
second assistant retracts the wire gently from the endoscope
biopsy port. It is essential that throughout the procedure, a
bile catheter covers the transhepatic section of the guidewire.

Fat liver laceration has occurred because of traction on
the unprotected guidewire during insertion of the stent.

Once sufficient guidewire is in the hands of the endoscopy
assistant, then any wire guided accessory can be used
through the endoscope; sphincterotome, balloon dilatation
or stenting, being carried out as necessary. When inserting a
stent through a stricture affecting the hepatic or intra-
hepatic ducts, it can be difficult to judge the length of the
stent accurately, so that its tip is not inserted into the
hepatic parenchymal tract. To avoid this possibility it is
best to advance the endoscopic catheter up into the intra-
hepatic ducts and then to remove the guidewire. The per-
cutaneous catheter can be left in position while the flexible
tip of a new endoscopic wire is passed through the endo-
scopic catheter and into a more vertically orientated intra-
hepatic bile duct radicle. In this way the stent can be
inserted without risk of it passing into the track. If, despite
this, the stent does become lodged in the hepatic track it
can be repositioned by using a biliary dilatation balloon
passed either percutaneously to push the stent out of the track or endoscopically to pull it out into a more acceptable
position. Alternatively, a less expensive way of repositioning the
stent, is to insert a standard sphincterotome endo-
scopically into the distal portion of the stent after which an
assistant bows the sphincterotomy thereby gripping the stent tightly from within. Slight downward angulation of the
endoscope will withdraw the stent fractionally into an acceptable
position.

Once adequate duct drainage has been established, the
percutaneous catheter can be withdrawn. Although some
workers prefer to leave the catheter in situ for 24 to 48
hours after endoscopic stent insertion this is rarely neces-
sary and removal of the catheter permits the patient to
return home the day after stent placement. If drainage is
inadequate, then the catheter can be left in situ for further
cholangiography or further procedures as necessary. Stents
inserted in this way can be changed endoscopically using
simple stent exchange procedures, without risk of having to
repeat the combined procedure.12

The combined procedure is an effective and versatile
 technique, permitting selective intrahepatic duct access with
percutaneous fine bore catheters, but also permitting the
benefits of large bore stents for drainage thereby minimising complications. The days of the combined procedure,
however, for the treatment of malignant disease may not
be numbered. Expandable metal stents with an internal
diameter of up to 30 Fr can be introduced through a
transhepatic track of as little as 7 Fr. Stent insertion can
usually be achieved at the initial PTC.13 Although these
wide bore metal stents do not remain patent indefinitely,
they do have a longer life span than plastic stents of more
limited calibre.14 It may be that when initial endoscopic
stent placement fails, then percutaneous metal stent
insertion is the quickest, most effective, and long lasting
course of action for the patient.

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