The predictive value of transabdominal ultrasonography in the diagnosis of biliary tract complications after orthotopic liver transplantation

S H Hussaini, M B Sheridan, M Davies

Abstract

Background—In transplant recipients with choledococholedocostomy (CDCD), endoscopic retrograde cholangiopancreatography (ERCP) remains the gold standard for the diagnosis of biliary leak or strictures. Transabdominal ultrasonography (TAUS) has been used to screen patients with suspected biliary tract complications, prior to ERCP, although the clinical effectiveness remains unclear.

Aims—To assess the predictive value of TAUS in the diagnosis of biliary tract complications after liver transplantation.

Methods—144 consecutive ERCP and corresponding ultrasonogram reports performed over a 67 month period in 79 patients after liver transplantation were analysed retrospectively.

Results—77 ERCP patients had both a TAUS and a successful ERCP. Biliary tract abnormalities were found at TAUS in 49 (64%) of the 77 patients. TAUS had an overall sensitivity of 77%, and specificity of 67%, with positive and negative predictive values of 26% and 95% respectively, when adjusted for the prevalence rate of biliary complications after liver transplantation of 12.8% in our population. The use of bile duct calibre as sole criterion for an abnormal scan improved the specificity (76%) and with a corresponding reduction in sensitivity (66%). The risk of false negative TAUS was similar in both the early and late post-transplant periods.

Conclusions—A normal TAUS after liver transplantation with CDCD makes the presence of biliary complications unlikely.

Keywords: endoscopic retrograde cholangiopancreatography; transabdominal ultrasonography; orthotopic liver transplantation; predictive value; sensitivity; specificity

Biliary tract complications after orthotopic liver transplantation are a cause of considerable morbidity and mortality. The advent of modified techniques of biliary reconstruction such as choledococholedocostomy (CDCD), increasingly without the use of a T tube stent, has reduced the incidence of biliary complications after liver transplantation.

Biliary complications after transplantation have clinical and laboratory features similar to those of acute or chronic rejection, sepsis, post-transplant hepatitis, or hepatic artery occlusion. In transplant recipients with CDCD, endoscopic retrograde cholangiopancreatography (ERCP) remains the gold standard for the diagnosis of biliary leak or strictures. However, ERCP is an invasive investigation with a small but significant morbidity and mortality. Thus transabdominal ultrasonography (TAUS) has been used to screen patients with possible biliary tract complications. Unfortunately, TAUS is associated with false negative results, although these data refer to earlier transplant series when CDCD was uncommon. Thus the aim of the current study was to assess the predictive value of TAUS in the diagnosis of biliary tract complications prior to ERCP.

Methods

DATA ACQUISITION

Patients were identified retrospectively from the Radiology Department database, as those who underwent ERCP between October 1991 and April 1997 following liver transplantation at St James’s University Hospital. In total, 144 consecutive ERCPs performed in 79 patients were identified, 43 of whom had a single procedure. A total of 101 ERCPs was performed in the remaining 36 patients. The mean number of ERCPs per patient was two (range 1–5, median 1). In 10 patients, repeat ERCP was performed for a clinical indication which was distinct from the index episode, such as an episode of possible biliary obstruction in a second liver graft. In the remaining 26 individuals who underwent multiple ERCPs, the indication for repeat ERCP was for stent placement, removal, or replacement, and for failed initial cannulation of the common bile duct; these repeat ERCPs were excluded from the studies of the predictive value of TAUS. Thus a total of 89 ERCPs from 79 patients was suitable for data analysis. However, 12 of these 89 ERCPs were excluded from data analysis for the following reasons: no ultrasound before ERCP (n=8); no cholangiogram obtained at ERCP (n=3); or no cholangiogram obtained at ERCP or TAUS performed pre-ERCP (n=1). Therefore, in all, there were 77 evaluable cases of

Abbreviations used in this paper: CDCD, choledococholedocostomy; ERCP, endoscopic retrograde cholangiopancreatography; PTC, percutaneous transhepatic cholangiography; TAUS, transabdominal ultrasonography.
ERCP was taken as the gold standard for a “true positive” with a cholangiogram which had the following radiological findings: (1) biliary stricture (anastomotic or non-anastomotic); (2) leak of contrast; (3) sludge and/or stones; and (4) biliary dilatation (greater than the calibre of the duodenoscope) with no obstructive lesion. The median time between biliary TAUS and ERCP was five days (range 1–71 days).

STATISTICS
The usefulness of TAUS in the detection of biliary complications after liver transplantation was initially assessed by calculating the sensitivity (percentage of true positive scans correctly identified by TAUS) and specificity (percentage true negative scans correctly identified by TAUS) using the cholangiogram obtained at ERCP as the gold standard. The predictive value of TAUS was calculated as the percentage of patients with an abnormal scan who had an abnormal cholangiogram (positive predictive value) and percentage of patients with a normal scan who had a normal cholangiogram (negative predictive value). The predictive value was then adjusted for the prevalence rate of biliary complications. The TAUS results were analysed using all positive criteria and using biliary dilatation as the sole positive criterion. The predictive value of TAUS was also analysed in the early (ERCPs performed within 100 days) and late (ERCPs performed after 100 days) periods after transplantation.

The difference in predictive value in the early and late transplant periods was compared using Fisher’s exact test. The level of significance was set at p<0.05. Results were expressed as mean values (SEM) or medians as appropriate. Data were analysed using StatCalc, version 5 and Excel, version 5.0.

Results
CLINICAL INDICATIONS FOR ERCP
A total of 49 abnormal TAUS was reported prior to ERCP, the details of which are shown in fig 1. Intrahepatic or extrahepatic biliary dilatation was observed in 61% of patients with an abnormal TAUS, although the remaining patients had suspicious intra-abdominal fluid collections with normal duct calibre. A normal TAUS was reported before ERCP in 28 patients. The major indications for ERCP in these patients were as follows: cholestasis liver function tests with a serum bilirubin greater than 100 µmol/l and/or alkaline phosphatase greater than 500 IU/l (n=24); hepatic artery occlusion shown by angiogram (n=1); and late transplant period (n=2).

Table 1 Comparison of transabdominal ultrasonography (TAUS) and endoscopic retrograde cholangiopancreatography (ERCP) findings

<table>
<thead>
<tr>
<th>ERCP</th>
<th>Abnormal</th>
<th>Normal</th>
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<tr>
<td>TAUS</td>
<td></td>
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<tr>
<td>Abnormal</td>
<td>41 (84%)</td>
<td>8 (16%)</td>
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<tr>
<td>Normal</td>
<td>12 (43%)</td>
<td>16 (57%)</td>
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an abnormal T tube cholangiogram (n=2); and cholangitis alone (n=1).

ERCP FINDINGS AFTER TRANSPLANTATION
Biliary tract abnormalities were found at ERCP in 53 of the 77 patients analysed. The cholangiogram performed at ERCP was normal in 24 patients (31%). A total of 41 patients had a biliary stricture, 36 of which were anastomotic, two anastomotic with associated biliary leaks, two with combined anastomotic and non-anastomotic, and one non-anastomotic stricture alone. Common duct dilatation was seen in five patients, one of whom had duct dilatation with small common bile duct stones. A further three patients had biliary sludge, casts, or stones in a non-dilated biliary system. Finally, four patients had biliary leaks.

PREDICTIVE VALUE OF TRANSABDOMINAL ULTRASONOGRAPHY

Table 1 gives the number of abnormal and normal ultrasonograms performed after transplantation, using ERCP as the gold standard. Table 2 gives the data for sensitivity, specificity, and crude and adjusted predictive values for transabdominal ultrasonography in the detection of biliary abnormalities after transplantation. In those patients transplanted between October 1991 and April 1997, the prevalence of biliary complications during the post-transplant period was 12.8%. This prevalence rate was considerably greater than in two early studies which reported sensitivity rates between 38% and 45%. CDCD was 12.8%. This prevalence rate was considerably greater than in two early studies which reported sensitivity rates between 38% and 45%.

Table 2 Predictive value of transabdominal ultrasonography

<table>
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<tr>
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<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Positive</th>
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<tr>
<td>Overall</td>
<td>77</td>
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<tr>
<td>Dilated ducts</td>
<td>66</td>
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ERCP, endoscopic retrograde cholangiopancreatography.

Discussion
End to end CDCD is the preferred biliary anastomosis in 75% of adult liver transplant operations. CDCD without T tube drainage is often performed, and therefore TAUS, followed by ERCP, is currently used to evaluate and treat biliary complications arising after liver transplantation. The current study is unique in that the clinical effectiveness of TAUS has been evaluated in a large number of post-transplant patients from a single centre who underwent CDCD in the majority of cases. We have shown that TAUS after liver transplantation with CDCD has good predictive value for biliary complications.

The presence of fever, ascites, cholestatic liver function tests, and jaundice are suggestive of biliary complications, although the differential diagnosis includes acute and chronic rejection, hepatic artery occlusion, and post-transplantation hepatitis. We used Doppler ultrasonography to establish the integrity of the hepatic vascular supply and biliary tree. Nonetheless, patients underwent ERCP, despite the finding of a normal transabdominal ultrasonogram, if there was clinical suspicion of biliary complications. The rationale for this diagnostic approach was the poor sensitivity of TAUS after liver transplantation in the detection of biliary complications documented in earlier reports. Therefore, although the current study was retrospective and thus subject to selection bias, we believe that the sensitivity and specificity of TAUS as a screening investigation has been validly assessed, as the diagnostic algorithm used during this study did not assume that TAUS was a reliable indicator of biliary complications.

The sensitivity of TAUS in the detection of biliary complications in the present series was considerably greater than in two early studies which reported sensitivity rates between 38% and 45%.

Table 1 gives the number of abnormal and normal ultrasonograms performed after transplantation, using ERCP as the gold standard.

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We speculate that the use of T tube drainage in these earlier studies may have reduced the diagnostic effectiveness of TAUS. Moreover, we deliberately examined the use of ultrasound in patients prior to ERCP, rather than percutaneous transhepatic cholangiography (PTC). Patients undergoing PTC will usually have a Roux-en Y biliary reconstruction which may also limit the predictive value of ultrasound, as there is no extrahepatic biliary system to examine.

The negative predictive value of TAUS in the detection of biliary complications for a given individual was only 57%, which although better than earlier reports,12 is a cause for concern if TAUS is to be used as a screening technique. We found that the prevalence of biliary complications after liver transplantation was 12.8% of patients with a CDCD. Our results and those from other groups13–15 highlight the fact that the incidence of biliary complications has fallen in recent years. The low overall prevalence of biliary complications has practical implications for TAUS when used as a screening investigation in clinical practice. The predictive value of any investigation is not only determined by the sensitivity and specificity of the investigation, but also the prevalence of the screened abnormality.22 Thus, as biliary complications after liver transplantation become more infrequent, one can be more certain that a negative transabdominal ultrasonogram truly excludes biliary complications.

The risk of false negative transabdominal ultrasonograms seems to be similar in both the early and late post-transplant periods. The false negative scans arose for a number of reasons. Firstly, TAUS failed to detect small stones, sludge, and casts, as has been reported previously.10 Secondly, two patients had biliary dilatation alone, with no obstruction at cholangiography, although the significance of this finding is unclear. Finally, the delay in the time between ultrasound and ERCP may have accounted for the false negative TAUS in three of the seven patients with biliary strictures in whom the cholangiogram was obtained more than six days after TAUS.

In conclusion, we found that TAUS is a sensitive and specific method for the detection of biliary complications after liver transplantation. Indeed, when the incidence of biliary complications is relatively low, a normal scan after liver transplantation with an "end to end" biliary anastomosis makes the presence of biliary complications very unlikely.