

Infected percutaneous transhepatic cholangiography catheter and rescue hepaticogastrostomy in patient with gallbladder carcinoma



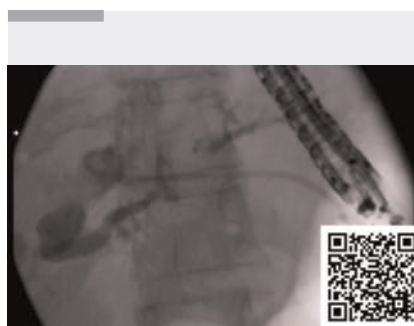
We present the case of a 58-year-old man with stage IV gallbladder carcinoma. The metastases of the liver caused obstructive jaundice, and due to the choledochal, cystic, and intrahepatic biliary duct metastases, endoscopic retrograde cholangiopancreatography (ERCP) was unsuccessful. Therefore, percutaneous transhepatic cholangiography (PTC) was performed.

The patient attended the oncology clinic because he had experienced several suppurative cholangitis episodes in the previous 4 months. The decision to remove the PTC catheter was related to erythema, swelling, and green-bluish suppurative biliary discharge due to *Pseudomonas* infection.

The computed tomography (CT) scan following intravenous contrast administration revealed multiple biliary tree metastases and an enlarged left intrahepatic biliary duct. Endoscopic ultrasound (EUS) (GF-UCT160-OL5, Olympus, Tokyo, Japan) guided the hepaticogastrostomy procedure, which was started in the biliary duct in segment II. After confirming the insertion of the biliary tree with bile drainage in the injector, a path was created, aided by a 6Fr cystotome (Endo-Flex GmbH, Voerda, Germany), and a 7Fr×10cm biliary pigtail stent (Endo-Flex GmbH, Voerda, Germany) was placed. The procedure was successful (▶ **Video 1**). The PTC catheter was removed after the procedure, and adequate antibiotic therapy with meropenem and vancomycin was prescribed for a week.

The biliocutaneous fistula from the PTC catheter line spontaneously closed 1 week after removal of the catheter. No complications related to hepaticogastrostomy or jaundice were observed during the 2-month follow-up period.

If the standard ERCP fails, especially for malignant diseases, EUS-guided punc-



▶ **Video 1** Endoscopic ultrasound-guided hepaticogastrostomy for rescuing an infected percutaneous transhepatic cholangiography catheter.

ture from the stomach to the biliary ducts can be performed for biliary drainage [1, 2]. PTC could also be performed, although it increases susceptibility to infection. The biliocutaneous tracts associated with the infected PTC line spontaneously closed after antibiotic treatment and adequate biliary drainage from the hepaticogastrostomy [3].

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Conflict of Interest

The authors declare that they have no conflict of interest.

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