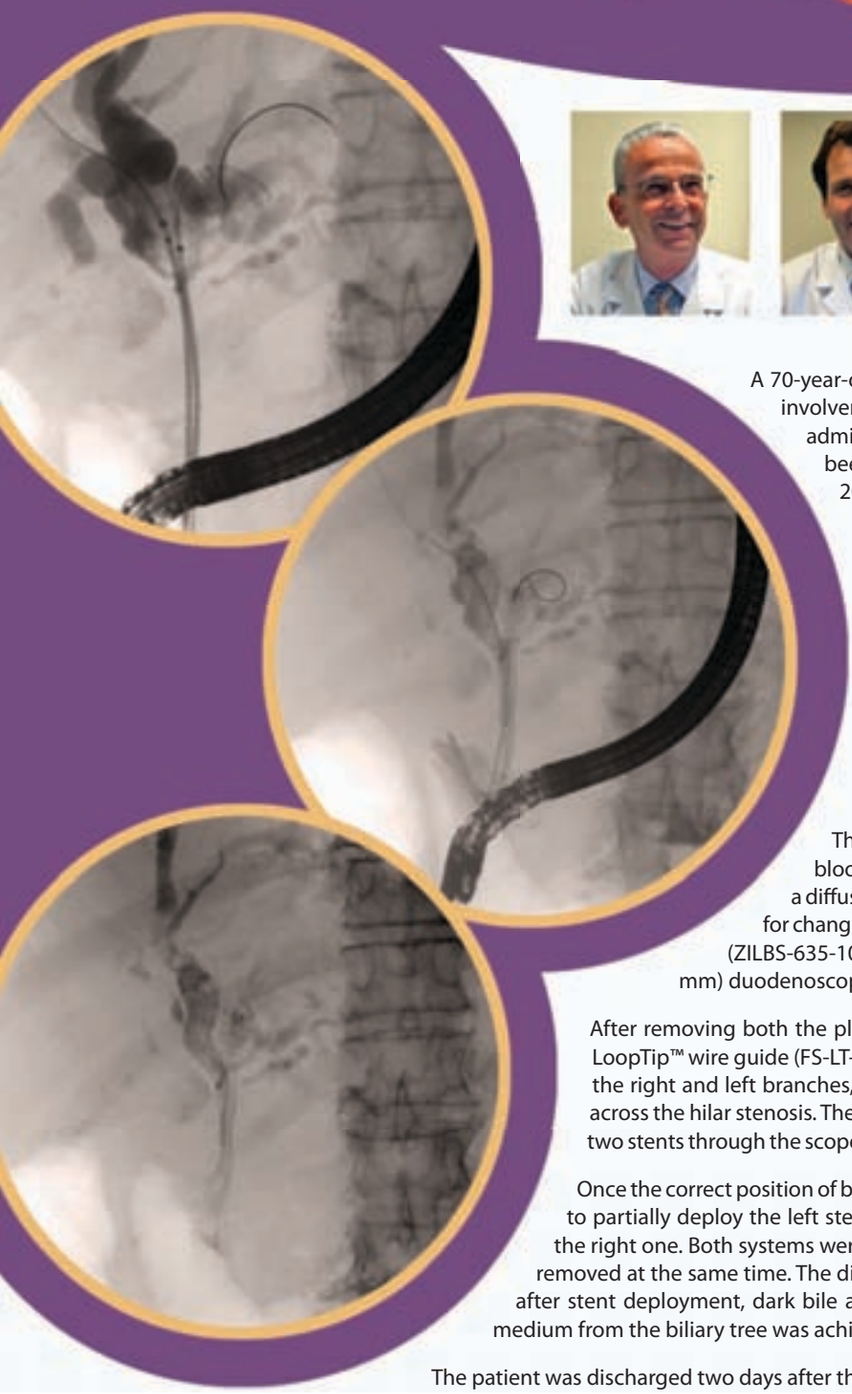
case report

Successful bilateral placement of Zilver 635 Biliary Self-Expanding Stents



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A 70-year-old patient with a six month history of cholangiocarcinoma with hilar involvement (Klatskin tumor class IIIb, according to Bismuth classification) was admitted to our department for acute cholangitis. The patient had previously been treated with chemotherapy and radiotherapy for breast cancer in 2005; past medical history was otherwise unremarkable.

Six months before, the patient came to our attention for jaundice and fever. A diagnosis of Klatskin tumor was made by imaging (helical CT and NMR). ERCP was subsequently performed for brushing (which confirmed the diagnosis of cholangiocarcinoma) and biliary stenting. After biliary sphincterotomy, 8.5 FR, 12 cm plastic stent (Cotton-Huibregtse, Cook) and 10 FR, 9 cm plastic stent were positioned (OASIS-Cook) in the left and right branch, respectively, and good drainage of the biliary tree was achieved. An explorative laparoscopy was subsequently made to evaluate the possibility of resectability, but the patient was considered unfit for surgery due to a nodal involvement.

The patient was jaundiced and febrile when admitted the second time. A blood culture resulted positive for E. Coli and abdominal ultrasound showed a diffuse dilation of the intrahepatic biliary tree. An ERCP was urgently planned for changing the previously placed biliary stents and positioning two metal stents (ZILBS-635-10-8) in the right and left branches. For this purpose, a large channel (4.2 mm) duodenoscope was used.

After removing both the plastic stents, a Tracer Metro® wire guide (METII-35-480) and a Fusion® LoopTip™ wire guide (FS-LT-35-480) were placed through a Glo-Tip II® ERCP catheter (GT-2-T-RB) in the right and left branches, respectively. Over the wire guides, the metal stents were positioned across the hilar stenosis. The stent catheters were lubricated with silicon spray, and insertion of the two stents through the scope was very easy. No problem occurred during cannulation of the papilla.

Once the correct position of both stents across the stenosis was confirmed by fluoroscopy, we started to partially deploy the left stent for about 15-20 mm, and immediately after we did the same with the right one. Both systems were then fully deployed simultaneously and both delivery systems were removed at the same time. The distal end of the right stent was seen out from the papilla. Immediately after stent deployment, dark bile and pus flowed out the papilla and a complete drainage of contrast medium from the biliary tree was achieved.

The patient was discharged two days after the procedure. At the 30-day follow-up visit, the patient was doing well, and total bilirubin was 2.3 g/dL.