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Summary

Difficult stones: Is it the stone or the endoscopist?

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Endoscopy | Hepatobiliary

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The speaker presented an educational approach to difficult biliary stones, arguing they should be stratified as different rather than difficult, with technique selection tailored to stone characteristics, biliary anatomy, and patient factors.

KEY POINTS

- The speaker stated that while 80-85% of biliary stones are managed with standard ERCP and sphincterotomy, the remaining 15% are difficult due to stone size (over 1.5 cm), biliary strictures, angulation, or altered patient anatomy.
- Large balloon papillary dilation is recommended by ESG guidelines as first-line for difficult stones and the speaker described it as very safe and easy, breaking the sphincter muscle to create a biliary highway for stone extraction.
- The speaker emphasized that large balloon dilation may not be effective when strictures are too tight or long, and presented a case where intraductal mechanical lithotripsy was used after a dormia basket became stuck above a stricture.
- Cholangioscopy-assisted lithotripsy was described by the speaker as effective, quick, and safe with higher success than mechanical lithotripsy, comparable adverse events, and reduced procedure time.
- The speaker presented a Roux-en-Y case treated with laparoscopic cholecystectomy and intraoperative antegrade cholangioscopy through the cystic duct, with stone extraction and no sphincterotomy performed.
- In the Q&A, the speaker recommended that if perforation occurs during large balloon dilation, the perforation becomes the priority, managed with fully covered metal stent or nasobiliary drainage and delayed stone removal two to three weeks later.

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