

The basics: Differential diagnosis of biliary strictures

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Presentation

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The speaker presented a diagnostic algorithm for biliary strictures, emphasizing that most are malignant and recommending MRI with MRCP as superior imaging, combined with tailored tissue acquisition strategies based on stricture location.

KEY POINTS

- The speaker stated that approximately 55% of biliary strictures without a clear mass are malignant, rising to almost 90% when abdominal masses are included, making malignancy exclusion the priority.
- For distal biliary strictures, the speaker recommended combining US tissue acquisition with ERCP brushing and biopsy for highest diagnostic accuracy, reporting ERCP brushing sensitivity of 45% and combined sensitivity of 60% versus 83% for US tissue acquisition.
- MRI with MRCP showed significantly higher accuracy than contrast-enhanced CT scan in the speaker's meta-analysis and should be preferred when available for both stricture detection and malignancy diagnosis.
- CA19-9 demonstrated 81% pooled accuracy for discriminating malignant from benign strictures in the speaker's meta-analysis, significantly higher than CEA, though lab tests alone are insufficient.
- For perihilar strictures in surgical candidates, the speaker advised avoiding US tissue acquisition due to tumor seeding risk and recommended ERCP-based tissue sampling instead.
- Cholangioscopy provided an incremental diagnostic yield of 27% in patients with indeterminate biliary strictures after initial ERCP, according to the speaker.

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