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Summary

Stones in altered anatomy

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Endoscopy | Hepatobiliary

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This presentation reviews endoscopic strategies for bile duct stone removal in surgically altered anatomy, emphasizing pre-procedure planning, scope and accessory selection based on anatomic complexity, and the role of EUS-guided techniques when standard enteroscopy-assisted ERCP fails or is impractical.

KEY POINTS

- The speaker categorizes altered anatomies by difficulty: Billroth I and simple gastroplasties allow standard duodenoscope use, Billroth II and conventional Whipple procedures can use standard scopes, Roux-en-Y hepaticojejunostomy requires longer scopes, and biliopancreatic diversion with duodenal switch is considered too difficult for the speaker to attempt endoscopically.
- For enteroscopy-assisted ERCP in altered anatomy, the speaker reports meta-analysis success rates of approximately 90% for reaching the target and 76-90% for completing ERCP, though success drops to around 80% specifically for Roux-en-Y anatomy, with adverse event rates of 4-6%.
- Short single balloon enteroscopy with 1500mm length and 3.2mm channel is presented as having better outcomes than long single balloon enteroscopy for these procedures.
- EUS-directed transgastric ERCP is described by the speaker as equivalent to laparoscopy-assisted ERCP for success and access in Roux-en-Y gastric bypass cases, with the advantage of shorter procedure time.
- The speaker recommends EDGE as the preferred first approach for Roux-en-Y gastric bypass if the facility and expertise are available, with enteroscopy-assisted ERCP or EUS-guided rendezvous as alternatives when EDGE is unavailable or fails.

– In the Q&A, the speaker states his technique for distending the biliopancreatic limb before EDGE involves placing a nasocatheter and insufflating through it, and agrees that laparoscopic cholecystectomy with same-session laparoscopy-assisted ERCP is sensible when the gallbladder is intact.

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