Laparoscopic Transcystic Common Bile Duct Exploration (LCBDE)

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SpyGlass™ Discover Digital Catheter Technique Spotlight

Presented by:

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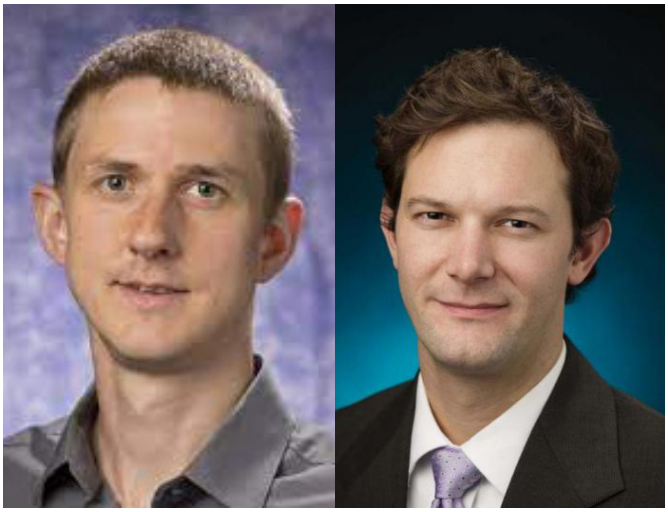
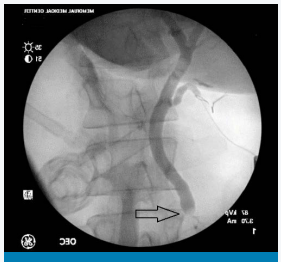


Patient Presentation:

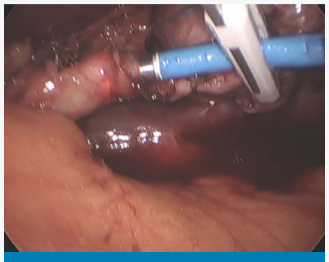
A 44-year-old male with history of Roux-en-Y gastric bypass presented with epigastric abdominal pain, leukocytosis, and hyperbilirubinemia. On abdominal CT and ultrasound, he was found to have evidence of acute cholecystitis. Subsequent MRCP revealed choledocholithiasis.

Procedure:

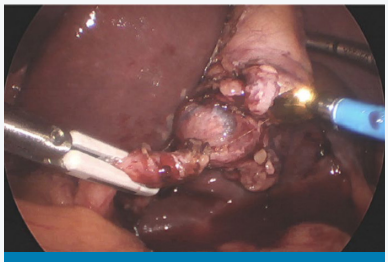
He was taken for laparoscopic cholecystectomy and intraoperative cholangiogram revealed a filling defect. (figure 1) He had been consented for laparoscopic assisted ERCP. However, his remnant stomach was difficult to access due to intraabdominal adhesions. Instead, laparoscopic transcystic common bile duct exploration (LCBDE) was performed. (figure 2) No dilation of the cystic duct was required, and the scope was passed easily into the common bile duct. A calculus was readily identified and removed using basket extraction. (figure 3) Post stone extraction we were able to use SpyGlass Discover Digital Catheter to identify the ampulla and confirm ductal clearance. (figure 4)



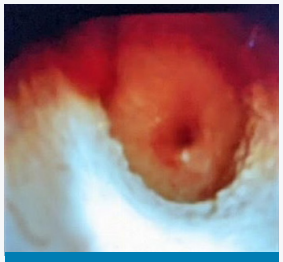
Defect (figure 1).



Performed (figure 2).



Extraction (figure 3).



Clearance (figure 4).

Discover Impact

Post-operatively, his diet was advancedand antibiotics were discontinued. His symptoms had improved the following morning and bilirubin was stable. He was discharged home on post-operative day one.

Discussion:

Choledocholithiasis frequently requires management with ERCP as well as surgical cholecystectomy for prevention of recurrenceand often concurrent cholecystitis. This is further complicated in patients with Roux-en-Y anatomy, making a traditional endoscopic approach ERCP impossible. The Choledochoscope enabled us to remove the common bile duct stone at the same operation, using the cystic ductotomycreated for the cholangiogram. This allowed us to forego the risk and time required for dissection of the remnant stomach, additional incision and port placement in the stomach, as well as the need to involve a gastroenterology team. In this patient's case, the recovery was fast and significant risk to the patient was avoided.

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