Percutaneous transbiliary biopsy

Biópsia percutânea transbiliar

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ABSTRACT

Percutaneous drainage of the bile ducts is an established procedure for malignant obstructions, in which a histological diagnosis is often not obtained. We describe the biopsy technique of obstructive lesions through biliary drainage access, using a 7F endoscopic biopsy forceps, widely available; some are even reusable. This technique applies to lesions of the hepatic ducts, of the common hepatic duct and of all extension of the common bile duct.

Keywords: Jaundice, Obstructive. Biliary Tract Neoplasms. Biopsy.

INTRODUCTION

Malignant obstructions of the bile ducts are part of the routine abdominal surgery services, often with extreme difficulty in cytological or histological diagnosis, especially in the high lesions. In these, drainage of the bile duct by trans-hepatic percutaneous access (PTBD) is performed routinely. However, few services perform cytological investigation with a brush or even biopsy of the obstruction by this access, delaying or preventing specific oncological treatment¹,².

In a large number of biliary lesions, size and location impede percutaneous access for biopsy and fragment removal for histopathological study³,⁴. Access through the biliary tract allows cytological examination of bile with a brush, but with low sensitivity and low availability. The forceps biopsy through the PTBD access is very little known in Brazil, and the technique described uses the more expensive and not widely available myocardial biopsy forceps³. In this paper, we describe the modified technique with a wired introducer sheath and an endoscopic gastric biopsy forceps, available at endoscopy services.

TECHNICAL NOTE

At the same time of the drainage or later, with the trans-hepatic access made, under prophylactic antibiotic therapy, we perform a cholangiography, identifying the site of the obstruction (Figure 1a). Under fluoroscopic guidance, we introduce a guidewire down to the point of obstruction and, over this, a 7F to 10F sheath, together with the dilator. Our preference is for a wired sheath that fits the curves better and does not kink. Wherever possible, we use the Flexor Ansel Sheath or Raabe Sheath short models. Once positioned within the obstruction, we keep the sheath firm and remove the guidewire and dilator (Figure 1b). We then introduce the 7F endoscopic biopsy forceps catheter, which has some reusable models. It is worth mentioning that there are models with needle or spike, with alligator type blades, among others. All can be used, however,
A drenagem percutânea das vias biliares é um procedimento estabelecido para obstruções malignas, nos quais, muitas vezes, não se consegue um diagnóstico histológico. Descrevemos a técnica de biópsia da lesão obstrutiva através do acesso de drenagem biliar, utilizando um fórceps de biópsia endoscópica 7F, amplamente disponível e alguns reutilizáveis. Esta técnica aplica-se a lesões dos ductos hepáticos, do hepático comum e de toda extensão do colédoco.


RESUMO
A drenagem percutânea das vias biliares é um procedimento estabelecido para obstruções malignas, nos quais, muitas vezes, não se consegue um diagnóstico histológico. Descrevemos a técnica de biópsia da lesão obstrutiva através do acesso de drenagem biliar, utilizando um fórceps de biópsia endoscópica 7F, amplamente disponível e alguns reutilizáveis. Esta técnica aplica-se a lesões dos ductos hepáticos, do hepático comum e de toda extensão do colédoco.


REFERENCES

DISCUSSION
As we have seen, it is a simple technique and quite similar to that already published with myocardial forceps3,4, but with a cheaper device, much more available in surgery services, and with some models authorized for reuse. Another great advantage is the possibility of biopsying lesions in the hepatic ducts, in the common hepatic duct or in the common bile duct, even in patients with intestinal or bilio-digestive derivations.

The presence of the pathologist in the room is of great value, but it is not the rule in many services. As patients remain with biliary drains, access is ready for repeating the biopsy when and if necessary. After about one or two weeks, if the result is inconclusive, everything can be repeated on an outpatient basis. Without a pathologist in the room, we obtained a positive result in 60% in the first procedure, reaching more than 80% after the second.

A simple and easily available technique, it allows the approach of high or low biliary obstructive lesions, speeding up and optimizing the onset of treatment.

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