ABCDDV/748

ABCD Arq Bras Cir Dig
2010;23(4):287-288

Letter to the Editor

CASE REPORT OF CIGARETTE LIKE COMMON BILE DUCT STONE: A RARITY AFTER CHOLEDOCHODUODENOSTOMY

Relato de caso de cálculo de colédoco em forma de cigarro: uma rara complicação após coledocoduodenostomia

Luciano Dias de Oliveira **REIS**, Anthony TR **AXON**

From the Hospital Nossa Senhora da Saúde, Santo Antônio da Platina, PR, Brazil.

Correspondence:
Luciano Dias de Oliveira Reis,
e-mail: reisluciano@uol.com.br

Fonte de financiamento: não há
Conflito de interesses: não há

Recebido para publicação: 08/06/2009
Aceito para publicação: 05/05/2010

INTRODUCTION

Choledochoduodenostomy has been reported since 19th century for benign and malignant diseases of common bile duct papilla and pancreas[1,6]. Nowadays progresses in interventional biliary endoscopy and radiology have drastically changed the diagnosis and treatment of choledocholitiasis and open exploration is used when these non operative methods fail. Lateral choledochoduodenostomy is a very effective way to treat stones in the common bile duct with low mortality and morbidity[1,6]. Long term complications are rare and related to stenosis of the anastomosis and due to sump syndrome[2,4,5,7,8]. Sump syndrome is a rare complication and is due to retention of food, debris and stones in the distal portion of the choledochus, between the papilla and the surgical stoma. What makes our cigarette like stone case distinct is that it was located in the common bile duct from the choledochoduodenostomy to the junction of right and left hepatic duct, different from sump syndrome when the stone is between the anastomosis and the hepatoduodenal papilla.

CASE REPORT

A 56 year old woman was submitted to a cholecystectomy and choledochoduodenostomy as treatment of choice to her gallbladder and common bile duct stones in December 1981. She remained well for many years. In July 2005, she was submitted to an endoscopy for heart burn. A symptomatic reflux esophagitis was confirmed. During the examination the endoscopist who performed her operation previously decided to examine her anastomosis. Surprisingly a yellow image was centered to the choledochoduodenostomy and was removed easily with a grasping forceps. The common bile duct was entered upwards to the junction of the right and left hepatic ducts and was clean (Figure 1). The stone removed had the size and caliber of a cigarette and its special feature resulted in this report.

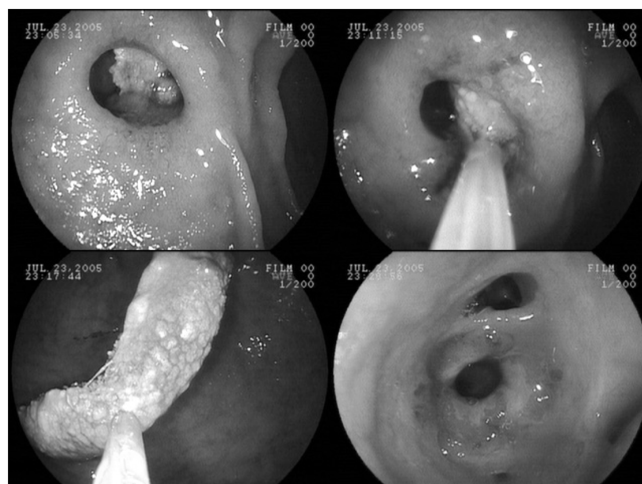

FIGURE 1 – Endoscopic images of the procedure showing clear biliary tree at the end

DISCUSSION

Cholecistectomy is the commonest major abdominal operation, and this is hardly surprising since 20 to 30% of people over the age of 40 years have gall stones. Around 15% of patients submitted to cholecistectomy will have symptoms of biliary colic and will need some form of exploration of the biliary tree[3]. Nowadays ultrasonography and ERCP are used to identify and to treat common bile duct stones but in the past per operative cholangiogram was frequently followed by surgical exploration and clearance of gallstones[3]. When the ducts were very dilated and surgical clearance of common bile ducts were not possible some kind of bile diversion was aimed by the surgeon and choledochoduodenostomy

was one of the favourite options[7].

Choledochoduodenostomy is also used for benign and malignant stenosis of the distal end of the common bile duct, for impacted stones at the papilla.

Advances of endoscopic tools and the increased number of experts in interventional biliary endoscopy have radically altered the management of choledocal calculi and disorders of the biliary tree. Choledochoduodenostomy has been surpassed by ERCP and papilotomy with the removal of stones or treatment of obstructions by endoscopic maneuver.

Choledochoduodenostomy is considered an excellent technique for biliary diversion. Is has low morbidity and mortality and few side effects[6]. Long term complications are rare. Among them are stenosis of the anastomosis, cholangitis, migration of food and parasites into the biliary tree and the "sump syndrome". The later is rarely seen[5,8] and it is due to the accumulation of material in the distal bile duct reservoir. This reservoir is located between the stoma of the choledochoduodenostomy and the hepatoduodenal papilla. The treatment of choice is endoscopic papilotomy and clearance of debris, food or calculi encased in the sump with good results[4,7].

In this case, the stone was located in the common bile duct, from the surgical stoma up to the meeting of the right and left hepatic ducts, filling it completely like a cast without obstruction. It was found due to curiosity of examining person after a long term choledochoduodenostomy during a routine upper gastrointestinal endoscopy.

REFERENCES

1. Artigas GV. Coledocoduodenostomia latero-lateral. Indicações e avaliação clinica dos seus resultados. Na. Paul. Med. Cir. 105(3):01-36, 1978
2. Baker AR, Neoptolemos JP, Carr-locke DL at al; Sump syndrome following choledochoduodenostomy and its endoscopic treatment. Br J Surg 72:433-35, 1985
3. Benson EAB, Keven R. Wedgwood, Axon ATR and Reis LDO. Coledocolitíase. In Aparelho Digestivo. Clínica e Cirurgia. Julio Coelho. 3ª edição Atheneu São Paulo. 1693-1705.
4. Caroli-Bosc FX, Demarquay JF, Peten EP, Dumas R, Burgeon A, Rampal P and Delmont JP Endoscopic management of sump syndrome after choledochoduodenostomy: retrospective analysis of 30 cases Gastrointest Endosc 51(2):180-83, 2000
5. Miros M,Kerlin P, Strong R et al. Post-choledochoenterostomy sump syndrome. Aust NZJ Surg 60:109, 1990
6. Nahrwold, DL. Choledochoduodenostomy. In Maingot Abdominal Operation. Appleton and Lange, tenth edition 1867-1874.
7. Polydorou A, Dowsett JF, Vaira D, Salmon PR, Cotton PB and Russel RCG.Endoscopic Therapy of the sump syndrome Endoscopy 21:126-30, 1989.
8. Venerito M, Fry LC, Rickes S, Malfertheiner P, Mönkemüller K Cholangitis as a late complication of choledochoduodenostomy: the sump syndrome. Endoscpy 41: E142-3