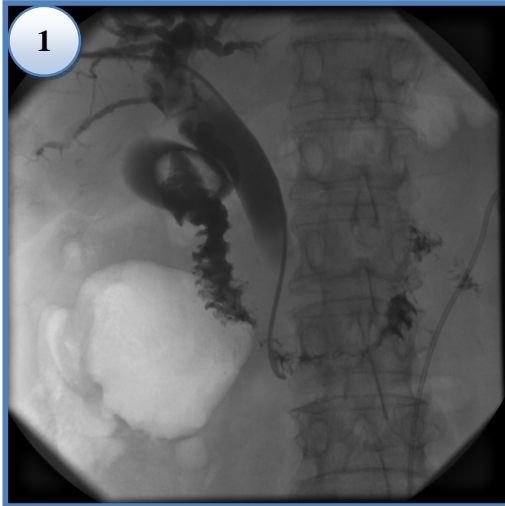


BVM

— 24 Hours a Day —

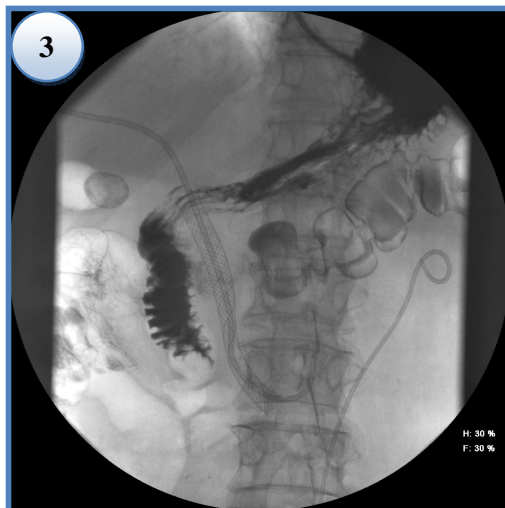
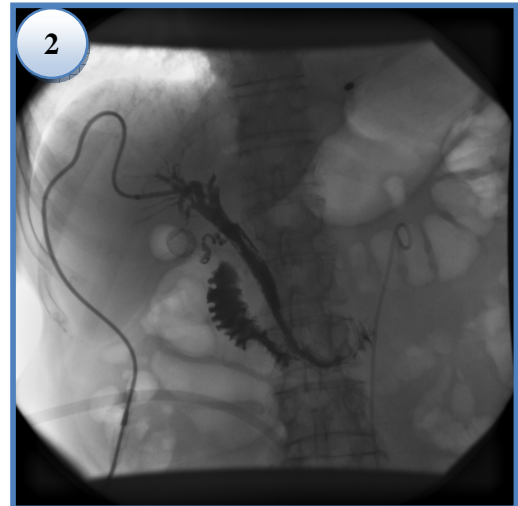
EGIS Biliary Case Report – Dr James Heron, Consultant Radiologist,
Worcestershire Royal hospital, Worcester.

Transhepatic insertion of biliary EGIS stent (Double Bare)



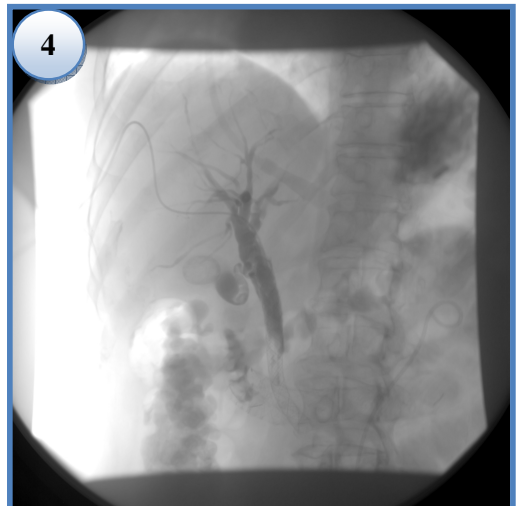
A 67 year old female patient with a previous history of ureteric transitional cell carcinoma presented with obstructive jaundice. CT showed an infiltrative mass around the second and third part of duodenum. A PTC was performed. Contrast injection demonstrated compression of the biliary tree at the ampulla with a stricture involving the distal second and third parts of duodenum (**image 1**).

A 10mm x 90mm Boston Scientific Placehit biliary wallstent was placed across the ampulla with distal end lying in the third part of duodenum (**image 2**).



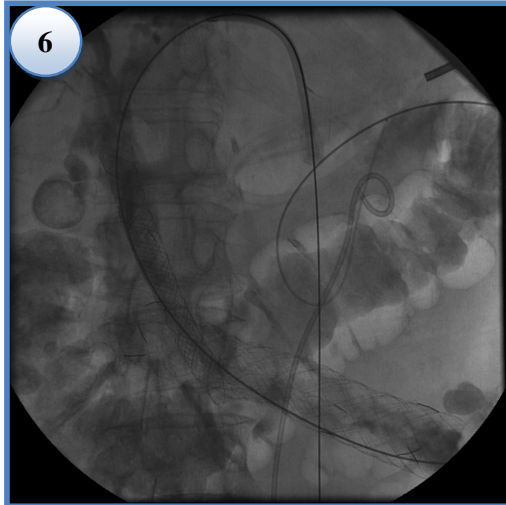
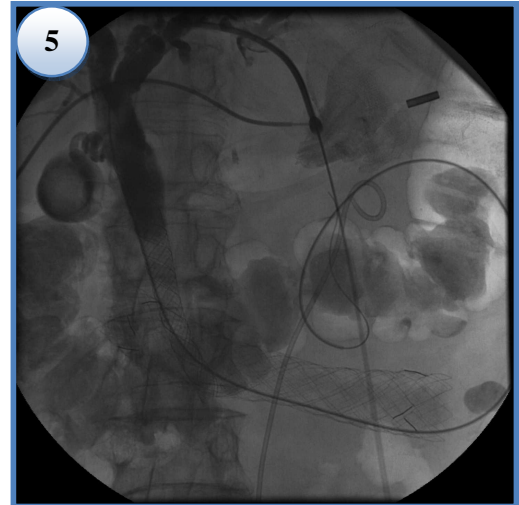
The patient subsequently developed a proximal small bowel obstruction (**image 3**) and re-attended for palliative duodenal stent insertion.

The duodenal obstruction was traversed trans-orally with placement of a 24mm x 120mm EGIS double-bare duodenal wallstent placed from second part of duodenum to distal third part with good clinical resolution of small bowel obstruction. However there was no demonstrable biliary drainage (**image 4**).



Patient re-attended for further biliary drainage. A left sided PTC was performed. Injection of contrast showed a dilated biliary tree with long occlusion from the mid-section of the in-situ stent within the CBD (**image 5**).

The occlusion was traversed. The guide wire was passed through the side of the intraduodenal component of the biliary wallstent and also through the side lattice of the duodenal stent (**image 5**).



Serial dilatation of the in-situ stent matrix was performed up to 8.6mm using angioplasty balloons with subsequent placement of a 10mm x 100mm EGIS double bare stent from the proximal common duct into the third part of duodenum (**image 6**).

Balloon dilatation of the stent was performed at the point of crossing the in-situ stents.

Ready drainage of contrast from the biliary tree into duodenum was demonstrated (**image 7**).

An external catheter was left in situ for 48 hours and removed without complication. Patient was subsequently discharged with near normal bilirubin and no symptoms of gastric outlet obstruction.

