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Endoscopic Management of Sump Syndrome Resulting from Endoscopic Choledochogastrostomy

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A 63-year-old man with metastatic ampullary adenocarcinoma presented with malignant biliary obstruction. He failed prior ERCP and percutaneous transhepatic biliary drainage attempts at an outside hospital. Repeat ERCP failed, and so EUS-guided transgastric biliary access was used to attempt a rendezvous ERCP, which failed due to failure of the wire to pass transpapillary. Thus, a transgastric choledochogastrostomy was performed by placing a lumen-apposing stent (Axios, Boston Scientific) under fluoroscopic and endoscopic guidance resulting in successful biliary decompression. The patient returned 1 week later with symptoms of cholangitis. Endoscopic evaluation of the choledochogastrostomy revealed digested food products filling the stent lumen and bile duct, consistent with sump syndrome (Fig. 1). Given recent placement of the transmural stent, removal was not feasible. A hydrophilic wire was passed through the lumen of the choledochogastrostomy and passed antegrade through the common bile duct exiting the ampulla. This wire was used to guide a rendezvous procedure; a side-viewing duodenoscope captured the wire, which was pulled back from the gastric lumen through the stent and into the common bile duct where it was guided into the common hepatic duct. A fully covered 10 mm by 8 cm metal stent was then placed to seal and exclude the transmural stent, extending transpapillary to allow for biliary drainage. At 5-month follow-up, sump syndrome had not recurred.

Supplementary Material

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Figure 1.
Choledochogastrostomy stent in place after partial removal of retained food products that had caused sump syndrome.