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Management of persistent bile leak after complex liver injury with a rendezvous procedure: Report of a case

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Bile leak after liver injury is not uncommon, especially in complex liver injury. Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy and biliary stent insertion is an effective treatment of bile leak after liver injury. However, ERCP is not always successful, resulting in the need of alternative interventions. We report a case with persistent bile leak after complex liver injury who had had a failed ERCP and subsequently underwent a successful rendezvous procedure for internal biliary stent placement.

Keywords: *Bile leak, liver injury, cholangiopancreatography , rendezvous procedure.*

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ศุภฤกษ์ ปรีชายุทธ, ศุภอัฐ ฝั่งพงพงค์, ปวันรัตน์ กระเนนภีรักษ์, สุวิทย์ ศรีอัษฎาพร, พสุรเชษฐ์ สมร, รัฐพลี ภาคอรธร, สุกัญญา ศรีอัษฎาพร, กฤตยา กฤตยาภิรณะ, พลินท์ ลิมปวิทยาพร, อภินันท์ รองวิริยะพานิช. การรักษาภาวะน้ำดีรั่วภายหลัง การบาดเจ็บที่ตับด้วยการใส่ท่อระบายในท่อน้ำดีด้วยวิธี รอง เดอ วูส์: รายงานผู้ป่วย 1 ราย. จุฬาลงกรณ์เวชสาร 2556 มี.ค. - เม.ย.; 57(2): 203 - 10

ได้รายงานผู้ป่วยบาดเจ็บที่ตับรุนแรงจากอุบัติเหตุรถจักรยานยนต์ ที่มีภาวะน้ำดีรั่วจากตับข้างขวาภายหลังการบาดเจ็บ ผู้นี้พินิจพยายามรักษาภาวะน้ำดีรั่วโดยการส่องกล้องทางเดินอาหารเพื่อใส่ท่อระบายในท่อน้ำดีแต่ไม่สำเร็จ เนื่องจากผู้ป่วยมีการตีบแคบของลำไส้เล็กส่วนต้นร่วมด้วย จึงตัดสินใจใส่ท่อระบายน้ำดีผ่านตับข้างซ้ายลงไปในรูเปิดท่อน้ำดีที่ลำไส้เล็กส่วนต้น เพื่อช่วยในการใส่ท่อระบายน้ำดีโดยการส่องกล้องทางเดินอาหารเป็นผลสำเร็จ (วิธี รอง เดอ วูส์) ทำให้น้ำดีหยุดรั่วในที่สุด และสามารถหลีกเลี่ยงการผ่าตัดในผู้ป่วยรายนี้ได้

คำสำคัญ : น้ำดีรั่ว, บาดเจ็บที่ตับ, ท่อระบายในท่อน้ำดี, วิธี รอง เดอ วูส์.

Bile leak after liver injury is not uncommon as it occurs in 1 - 4 % of liver injury patients.^(1,2) The incidence increases to 14 - 22% in complex liver injury (Association for the Surgery of Trauma Organ Injury Scale: AAST-OIS grade 4 and 5).^(3, 4) Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy and biliary stent insertion has been accepted as an effective treatment of bile leak after liver trauma with a high success rate (90 - 100%), thereby operative treatment can be avoided.^(5 - 8) Nevertheless, ERCP can sometimes be unsuccessful, resulting in the need for subsequent alternative interventions. Rendezvous procedure is an internal biliary stent placement technique using both percutaneous transhepatic and endoscopic approaches.^(9, 10) In this article, the authors report a complex liver injury patient with persistent bile leak who underwent initial unsuccessful ERCP and subsequent successful rendezvous procedure for internal biliary drainage.

Case Report

A 23-year-old man was transferred to our hospital after sustaining a motorcycle accident 17 days ago. At the first hospital, the patient was initially in shock with distended abdomen, thereby underwent immediate laparotomy. Severe (AAST-OIS grade 5) right lobe liver injury was found and perihepatic packing was performed. The patient was taken back to the operating room 4 days later for removal of packing and abdominal closure. However, he continued to bleed from the penrose drain placed at the perihepatic region and was eventually transferred to our hospital.

The initial computed tomography (CT) of the

abdomen at our institution revealed grade 5 liver injury with pseudoaneurysm at the right hepatic lobe, therefore angiography with selective embolization of right superior hepatic artery was accomplished on hospital day 2. The bleeding ceased after embolization, nonetheless, he developed bile leak from the penrose drain (approximately 200 - 300 ml/day) and fever. The patient was also unable to tolerate oral diet; hence, total parenteral nutrition and broad spectrum antibiotics were administered. A repeat CT of the abdomen on hospital day 17 showed a large biloma in the right hepatic lobe and duodenal obstruction due to external compression by collections at the subhepatic region (Figure 1). ERCP was attempted twice but duodenal papilla cannulation failed because of distorted anatomy of the duodenum. The subhepatic collections were then aspirated and the biloma was drained percutaneously via a pigtail catheter placed by interventional radiologists. Nasojejunal tube was also inserted endoscopically to provide enteral nutrition.

During the 2nd month in our hospital, the bile leak via the penrose drain decreased; however, the bile leak via the pigtail catheter placed in the right hepatic lobe continued. Thus, percutaneous transhepatic biliary drain (PTBD) was placed in the left hepatic duct by interventional radiologists in order to divert the bile flow from the right hepatic lobe on hospital day 58. Unfortunately, the bile leak persisted. At that time, the rendezvous procedure was planned. The left PTBD was then changed to a 12 French internal-external biliary drainage catheter with the distal end in the duodenum. A follow up CT of the abdomen demonstrated markedly decreased size of the biloma and subhepatic collections (Figure 2). Duodenal obstruction improved clinically since the patient could

tolerate oral diet well. The rendezvous procedure was then carried out on hospital day 117. The ERCP was performed; the guide wire was inserted into duodenum via the left PTBD, grasped by a forceps, and brought out of the endoscope via an operating channel. Cholangiography was then performed, demonstrating contrast leakage from the right hepatic duct (Figure 3). Subsequently, the PTBD was

withdrawn, sphincterotomy was done, and two plastic biliary stents were inserted over the guide wire into the left and right hepatic ducts (Figure 3). After the procedure, bile leak gradually stopped and the pigtail catheter was removed on hospital day 142. The patient was discharged on hospital day 147 and was scheduled for a repeated ERCP and stent removal in the next 3 months.

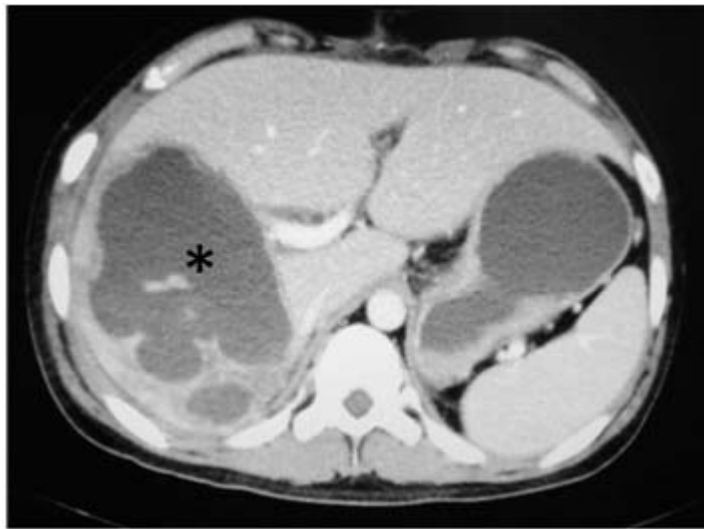


Figure 1A

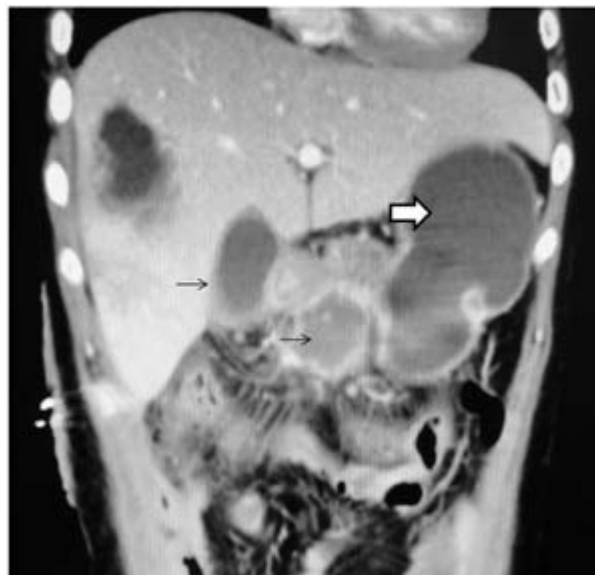


Figure 1B

Figure 1. A CT of the abdomen on hospital day 17;

Figure 1A An axial view shows a large biloma (*) occupying almost entire right hepatic lobe.

Figure 1B A coronal view shows a duodenal obstruction and a gastric dilatation (white arrow) due to external compression by collections at the subhepatic region (black arrows).



Figure 2A



Figure 2B

Figure 2. A CT of the abdomen on hospital day 84;

Figure 2A An axial view shows markedly decreased size of the biloma in the right hepatic lobe with a pigtail catheter (white arrow) and a left PTBD (black arrow) in place.

Figure 2B A coronal view shows resolution of subhepatic collections; the distal end of the left PTBD (black arrow) is in the duodenum.

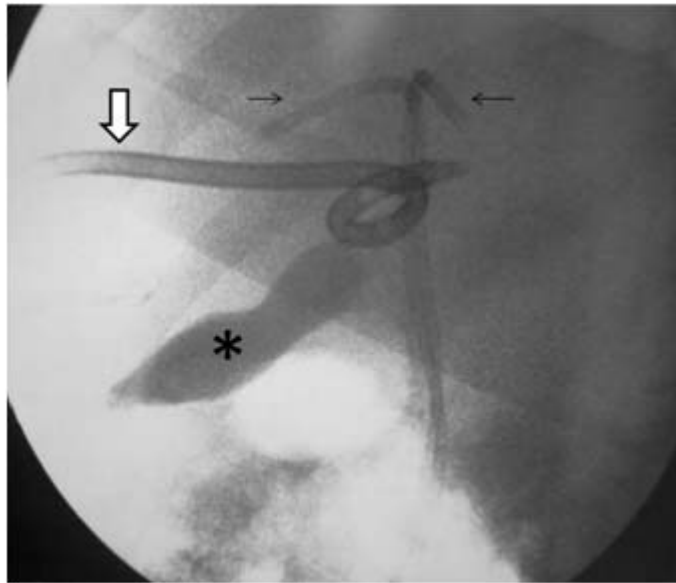


Figure 3. An X-ray at the end of the rendezvous procedure shows internal biliary stents placed in the common bile duct with their proximal ends in the right and the left hepatic ducts (black arrows). A pool of contrast media (*) leaking from the right hepatic duct and a pigtail catheter (white arrow) placed in the right hepatic lobe are also demonstrated.

Discussion

Management of complex liver injuries requires a multidisciplinary approach. Operative treatment and angiography with selective embolization are crucial for hemorrhage control, while ERCP with biliary stenting has become an important tool in diagnosing and treating post traumatic bile leak.⁽²⁻⁴⁾ Bile leak can be obvious as bile leakage through the drain site, similar to the presented patient; or may present as peritonitis or sepsis.^(1,11) Hepatoiminodiacetic acid (HIDA) scan is useful in diagnosing bile leak in patients with subtle clinical presentations, especially those undergoing a non-operative management.⁽¹¹⁾ The management options for bile leak after liver injury consists of observation, percutaneous drainage, biliary stent placement either via ERCP or percutaneous transhepatic approach, and operative treatment.^(1-4,8) Selection of the

treatment options depends mainly on the patient's condition, the adequacy of drainage, and facility of the institution.

ERCP with sphincterotomy and biliary stent insertion is a safe and effective method of managing bile leak after liver injury.⁽⁵⁻⁸⁾ However, it can be unsuccessful in difficult cases, as in our patient. Rendezvous procedure, a combined transhepatic-endoscopic internal biliary stent placement technique, has been utilized previously in the treatment of biliary obstruction^(10, 12, 13), biliary tract stones^(9,14), and bile duct injury⁽¹⁵⁾; with good results. To our knowledge, this is the first report on a rendezvous procedure in managing a patient with bile leak after liver injury. The guidewire inserted transhepatically into the duodenal lumen helps us tremendously in order to obtain a safe cannulation of the duodenal papilla, especially in the presence of difficult anatomy. This procedure requires

cooperation between trauma surgeons, endoscopists and interventional radiologists, again, emphasizing the need of a multidisciplinary team.

Conclusion

Management of bile leak after liver injury demands a multidisciplinary approach comprising percutaneous drainage, ERCP, and operative treatment. Rendezvous procedure is a viable therapeutic option in achieving internal biliary stenting when ERCP fails.

Conflict of interest statement

We hereby certify that there is no conflict of interest in this study.

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