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Benign CBD Stricture in an Operated Case of Gastro-Jejunostomy: A Case Report

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Case Report

Abstract: In the absence of symptoms of the primary disease, most patients with bile duct strictures (biliary strictures) remain asymptomatic until the lumen of the bile duct is sufficiently narrowed to cause resistance to the flow of bile. Occasionally, patients may have intermittent episodes of right upper quadrant pain (biliary colic), with or without laboratory features of biliary obstruction. Patients most often present with features of obstructive jaundice. On occasion, a patient may present dramatically with sepsis and hypotension due to ascending cholangitis. We report a case of benign CBD stricture in an operated case of gastro-jejunostomy who was operated with cholecystectomy and choledoco-jejunostomy and she recovered fully.

Introduction

The etiology of bile duct strictures is sometimes obvious at the time of presentation. In unclear cases, clues from the patient's history may help in making an accurate diagnosis. Most of the benign biliary strictures following injury during GI surgeries especially cholecystectomy go unrecognized at the time of surgery (as many as 75% of cases). Bile duct strictures (biliary strictures) can also occur as unexpected complications after other surgeries, such as gastrectomy, pancreatic surgery, or hepatic and portal vein surgery. Presentation after more than 5 years may occur in 30% of cases; therefore, a history of recent or past surgery should be sought in all cases. Information about the postoperative period, especially excessive drainage from surgical wounds and drains and episodes of fever, jaundice, and abdominal distention, are important in patients presenting shortly after surgery. Patients with cholangitis whose conditions fail to improve with conservative treatment usually require urgent decompression of the obstructed biliary system. Treatment options for bile duct strictures (biliary strictures) include (1) endoscopic or percutaneous balloon dilatation and insertion of an endoprosthesis or (2) surgery. Surgical management of benign bile duct strictures (biliary strictures) is necessary for patients with a low surgical risk in whom endoscopic therapy has failed. Surgical management consists of restoration of biliary enteric continuity, which usually is achieved with a defunctionalized Roux-en-Y jejunal loop by means of hepaticojejunostomy, choledochojejunostomy, or intrahepatic cholangiojejunostomy.

Case Report

A 70 year old female previously operated with Billroth II surgery i.e. partial gastrectomy and GJ stomy(Fig.1) presented to us with diagnosis of CBD dilatation with ascending cholangitis secondary to distal third benign CBD stricture. The diagnosis was made at AIG, Hyderabad on ERCP for which PT-CBD was done. (Fig.2)Patient presented with vague right quadrant abdominal pain and yellowness of skin and sclera with signs of sepsis. Investigations revealed deranged liver and kidney profile with leukocytosis. After a brief course of antibiotics and supportive treatment patient was explored.

Fig.1: *Billroth II*

Fig.2: *Distal CBD stricture with PT-CBD Partial Gastrectomy with G-J stomy*

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Surgery

Patient was explored by right upper Para median incision. It was found that right lobe of liver was enlarged with hugely dilated GB up to right lumbar region.(Fig.3) Proximal CBD was dilated up to 1.5 cms with sticturous segment in distal third of CBD. CBD dissected circumferentially and isolated with feeding tube. Cholecystectomy done.

Intraoperative upper GI scopy done with enterostomy in proposed site of choledochojejunostomy. GJ stomal site was patent without any ulceration, growth or bleeding.(Fig.4) Distal jejunal efferent loop delivered after making window through transverse mesocolon. CBD transected at the junction of middle and distal 1/3. Distal end closed and Choledochojejunostomy done. Choledochojejunostomy fixed to falciparum ligament and glissen's capsule. Transverse mesocolon window suture with delivered loop of jejunum.PT-CBD fixed.Post operativecholangiogram was showing normal flow of bile into jejunum(Fig.5)

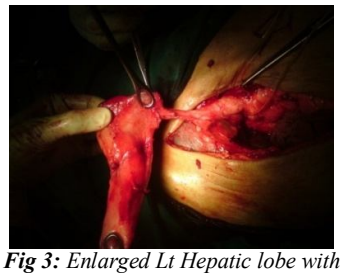

Fig 3: *Enlarged Lt Hepatic lobe with*

Fig 4: *Normal G-J stoma Dilated GB*

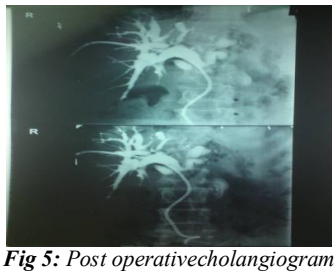

Fig 5: *Post operativecholangiogram*

Discussion

Only about 25% of major bile duct injuries (common bile duct or hepatic duct) are recognized at the time of operation. Most commonly, intraoperative bile leakage, recognition of the correct anatomy, and an abnormal cholangiogram lead to the diagnosis of a bile duct injury. More than half of patients with biliary injury will present within the first postoperative month. The remainder will present months or years later, with recurrent cholangitis or cirrhosis from a remote bile duct injury. CT scan and ultrasound also are important in the initial evaluation of the jaundiced patient, as they can demonstrate the dilated part of the biliary tree proximal to the stenosis or obstruction, and may identify the level of the extrahepatic bile duct obstruction. In the jaundiced patient with dilated intrahepatic ducts, a percutaneous cholangiogram will outline the anatomy and the proximal extent of the injury and allow decompression of the biliary tree with catheter or stent placements. An endoscopic cholangiogram demonstrates the anatomy distal to the injury and may allow the placement of stents across a stricture to relieve an obstruction.

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