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LETTER TO THE EDITOR

ERCP Through Gastrogastric Fistula in a Patient with Roux-en-Y Gastric Bypass Anatomy

C. Roberto Simons-Linares[1] · Prabhleen Chahal[1]

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To the Editors,

ERCP in patients with Roux-en-Y gastric bypass (RYGB) anatomy remains challenging. Traditionally, balloon-assisted ERCP has been attempted but it is very time-consuming and success rates are reportedly 55–63% [1–3]. In addition, laparoscopy-assisted approach with gastrostomy creation to access the gastric remnant has also been traditionally performed with high success rate but is more invasive and resource-utilizing. Endoscopic ultrasound-directed transgastric *ERCP* (EDGE) procedure is a relatively new approach that has been shown to be effective and less invasive. This procedure involves creation of a fistula with placement of lumen apposing metal stent (LAMS) between the gastric remnant and gastric pouch or Roux limb. However, some patients develop asymptomatic spontaneous gastrogastric fistula (GGF) post RYGB. We describe one such case of a 71-year-old woman with hypertension, diabetes type II, and history of RYGB (performed in 2004) who was admitted with fever, right upper quadrant abdominal pain, vomiting, and jaundice that started 1 week prior to admission. Initial laboratory workup revealed mild leukocytosis of 9.8 k/μL, direct bilirubin 8.8 mg/dL, alkaline phosphatase of 291 mg/dL, AST 34, and ALT of 43 mg/dL. Right upper quadrant ultrasound demonstrated common bile duct (CBD) dilation of 10 mm and a 7-mm stone in the distal (CBD) and abdominal computed tomography (CT) demonstrated distal CBD obstruction with multiple stones. Due to her RYGB anatomy, she underwent emergent percutaneous transhepatic cholangiogram (PTHC) with placement of internal external biliary drainage catheter placement with failed removal of choledocholithiasis. *EDGE* procedure was planned. Upper endoscopy was performed and surprisingly, it revealed a 12-mm gastrogastric fistula (Fig. 1). The standard duodenoscope was advanced through the fistula and ERCP was performed in standard fashion (Figs. 2 and 3).

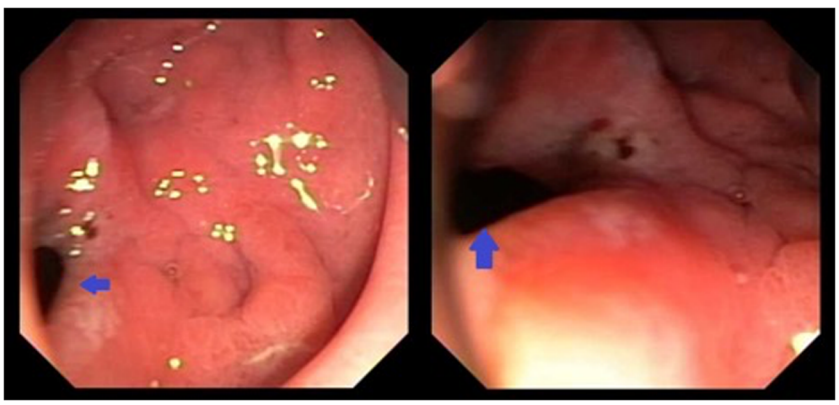

Fig. 1 Endoscopy: The blue arrows point towards 12-mm GGF

✉ Prabhleen Chahal
chahalp@ccf.org

[1] Gastroenterology and Hepatology department, Digestive Disease Institute, Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195, USA

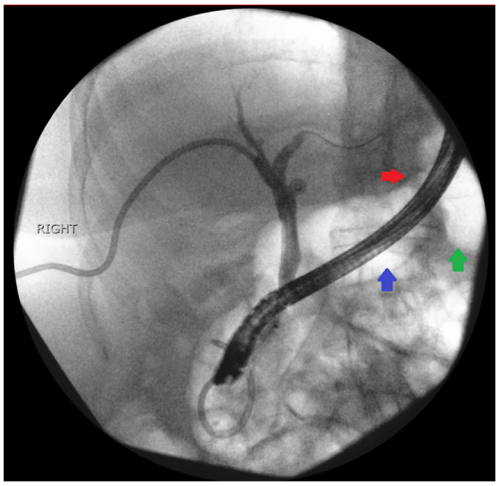

Fig. 2 Aerogram: Red arrow points towards GGF, green arrow to gastric pouch, and blue arrow to the gastric remnant

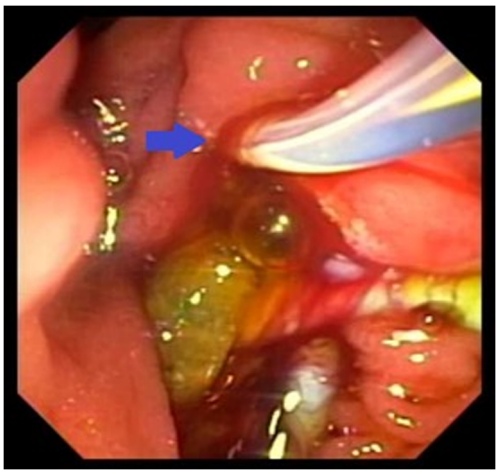

Fig. 3 ERCP with cannulation of the papilla and sludge coming out from it

Choledocholithiasis was found and multiple stones were removed from the CBD. There were no post-procedure complications. She completed a 7-day course of antibiotics and underwent laparoscopic cholecystectomy. She remains symptom free at 6-month follow-up with steady weight. In summary, we presented a case of ERCP through asymptomatic spontaneous GGF in a patient with remote history of RYGB. The exact incidence of GGF is unknown and the diagnosis can be delayed as not uncommonly, these patients remain asymptomatic [4]. Endoscopists should be aware of this known complication of RYGB (a much welcome serendipitous finding in this case!) as GGF can allow easy endoscopic access of the gastric remnant in RYGB patients.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

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