

심한 담도 협착에서 Soehendra stent retriever를 사용한 담도 확장 1예

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서론: 담도나 췌관의 양성 또는 악성 협착의 확장을 위해서는 풍선 카테터나 확장 카테터를 사용하는 것이 일반적인 방법이나 심한 협착이 있는 경우에는 이와 같은 확장 방법으로는 만족할 만한 성과를 거두지 못했었다. Soehendra stent retriever는 담도나 췌관에 파문된 스탠트를 교체하기 위해 사용되어 온 장비이나 최근 고도의 악성 담도 협착에서 사용된 예가 보고되고 있다. 이에 저자들은 Soehendra stent retriever를 사용하여 고도의 담도 협착을 확장시켜 배액술을 성공시킨 증례 1예를 보고하는 바이다.

증례: 60세 남자 환자가 1개월 전부터 시작된 상복부 및 심와부 통증과 식사를 거의 못하면서 계속되는 오심과 구토를 주소로 인근 병원에 내원하였다. 지난 1개월간 10Kg의 체중감소가 있었고 공막에 황달이 관찰되었으나 이전에 다른 분대로 입원한 병력은 없었다. 검사 소견상 백혈구수 10,850/mm³, 혈색소 9.8 g/dL, 혈소판수 237,000/mm³ 이었고 생화학 검사상 AST/ALT 239/237 IU/L, TB/DB 17.3/10.8 mg/dl, ALP/LDH 4304/678 IU/L, BUN/CRE 13/1.1 mg/dl, PT/PTT 13.8/1NR 1.25/43.6, amylase/lipase는 426/120IU/L로 증가되어 있었다. 응급으로 시행한 복부 초음파 검사에서 신 담도의 확장을 확인하였으며 복부 컴퓨터 단층 촬영에서도 전 담도의 확장과 함께 췌두부암의 소견이 보여 본원으로 전원되었다. 응급으로 시행한 ERCP에서는 원위 총담도의 폐쇄로 인해 담도가 조영되지 않았으며 담도내로 guide wire 삽입을 시도했으나 guide wire가 원위 총담도를 통과하지 않았다. 수차례 시도한 결과 겨우 guide wire를 폐쇄 부위 이상으로 진입할 수 있게 되었으나 ERCP catheter가 guide wire를 따라 진입할 수 없어 담도 조영을 시행할 수 없었다. 이에 Soehendra stent retriever를 폐쇄 부위 하부에 위치시킨 뒤 회전력을 주어 협착 부위를 관통시킨 뒤 ERCP catheter를 삽입하여 담도내 조영하였고 ERBD catheter를 밀어 넣을 수도 있게 되었다. 환자는 ERBD를 시행받은 뒤 황달의 감소와 통증의 감소를 보였으며 이후 통원 치료하다가 최근 담도 내 metal stent를 삽입하였으며 현재 외래에서 추적 관찰 중이다.

Common Bile Duct Perforation Developed During Simple Endoscopic Retrograde Cholangiography

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The clinical features of biliary tract perforation are important to physicians because they are associated with variable and serious complications and poor prognosis according to misdiagnosis. Variable etiologies of bile duct perforation could be divided into five clinical conditions as follows: 1) spontaneous, 2) surgery-related, 3) trauma, 4) procedure(PTBD, liver biopsy, etc)-related, and 5) endoscopic procedure-related, especially in endoscopic retrograde cholangio-pancreatography(ERCP). The type of endoscopic procedure-related perforation of bile duct could be divided into two type : therapeutic and diagnostic ERCP. The therapeutic ERCP-related perforations included endoscopic sphincterotomy (EST), guide-wire passing, dilatation(1) and biliary stent(2), and these were reported infrequently. The diagnostic ERCP-related perforation was very rare and only one case has been reported until now(3). We recently treated a rare case of bile duct perforation developed during diagnostic ERCP, and we would like to know the importance of this disease in respect to its clinical course and the possibility of pathogenetic mechanism through review of the related literature.

Case Presentation: A 57-year-old man was admitted to our hospital for evaluation of mild dilated biliary tract on abdominal ultrasonogram(USG). He complained intermittent RUQ abdominal pain. His past medical history was unremarkable and he was a social drinker. Abdominal physical examination showed mild tenderness without rebound tenderness on the RUQ abdomen. Laboratory data was normal except mild increase in GGT (209 IU/l). Abdominal USG showed mild dilatation of the biliary tract (about 1.2 cm in diameter of CBD) without evidence of definite obstructive lesion. We decided to perform ERCP and sphincter of Oddi(SO) manometry to rule out other disease such as a missed small stone in distal CBD or SO dysfunction. During ERC severe RUQ abdominal pain was followed by dye injection into the biliary tract. ERC showed that radio-opaque dye leaked from the duodenal side of CBD and dispersed along the extrahepatic bile duct and into the retroperitoneal cavity. The site of dye leakage was the point where was compressed by the tip of the injection catheter. We diagnosed this case as "a bile duct perforation developed during ERC" and inserted the Tannenbaum stent(10 F/ 11 cm). Three days after stent insertion the abdominal CT scan showed a small amount of fluid collection in the pericholecystic area and in front of the right kidney. He could be discharged without any abdominal pain or laboratory abnormalities 7 days after stent insertion. After 4 weeks the stent was removed and ERC was performed. The cholangiogram showed intact CBD without dye leakage and with multiple small stones in distal CBD, which were removed by EST and stone basket. We are able to contact this patient at the OPD without any problems up to these days. **Conclusion:** endoscopist have to be more careful to perform the ERC in patient who has a history of chronic cholangitis, and should be more careful to change the position in state of catheter insertion in bile duct, especially.