



Laparoscopic – Assisted ERCP for Choledocholithiasis after Gastric Bypass

David A. Iannitti Sr.¹, Erin Baker¹, Matthew Strand¹, Andrew Dries², Stephen Deal²

¹Division HPB Surgery; ²Section Advanced GI



Div. HPB Surgery
Charlotte, NC, USA

Background

Choledocholithiasis in the setting of an inaccessible ampulla, most commonly due to prior gastric bypass, can be a challenging clinical problem.

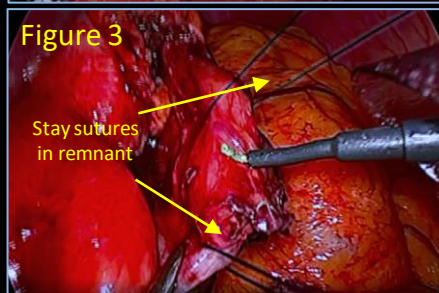
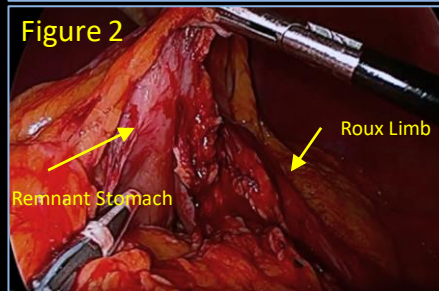
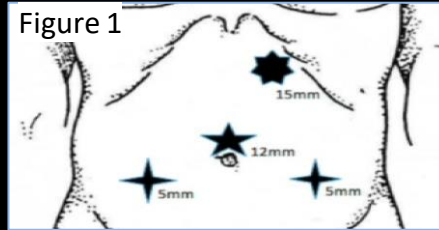
The case presented is a 39 year old woman with a prior gastric bypass who presented with pain and jaundice and was noted to have hyperbilirubinemia (total bilirubin 2.9) and choledocholithiasis by MRCP. Gallbladder was still in situ.

Technique

Given the lack of a dilated intrahepatic biliary system and the presence of a gallbladder, we elected to perform a laparoscopic-assisted transgastric ERCP and cholecystectomy.

Operative steps:

1. Port placement (Fig. 1). The 15 mm LUQ port is used as the access point into the stomach
2. Mobilization of the gastric remnant (Fig. 2) to the anterior abdominal wall with protection of the Roux limb
3. Suture placement on either side of gastrotomy site (Fig. 3)
4. Introduction of 15 mm port through the gastrotomy (Fig. 4)
5. ERCP via 15 mm trocar into remnant stomach with sphincterotomy and stone removal (Fig. 5)
6. Closure of the gastrotomy by suture or stapler (Fig. 6)
7. Cholecystectomy



Results

- Twenty-five cases (2017-2021)
- Median followup: 10 months
- Median length of stay: 2 days
- Complications: none greater than Clavien-Dindo grade 1
- One patient required repeat transgastric ERCP due to residual choledocholithiasis
- No patients required salvage transhepatic drainage

Conclusions

Laparoscopic assisted ERCP following gastric bypass for morbid obesity is a safe and effective approach for choledocholithiasis. This approach does not sacrifice or disrupt the gastric bypass. This approach is preferred particularly when cholecystectomy is needed. Transhepatic drainage can be avoided

