DISCLOSURE

M. Khashab is a consultant for Boston Scientific and Olympus America and has received research support from Cook Medical. A. Kalloo is a founding member, equity holder and consultant for Apollo Endosurgery. All other authors disclosed no financial relationships relevant to this publication.

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http://dx.doi.org/10.1016/j.gie.2013.12.004

EUS-guided drainage of a mediastinal abscess

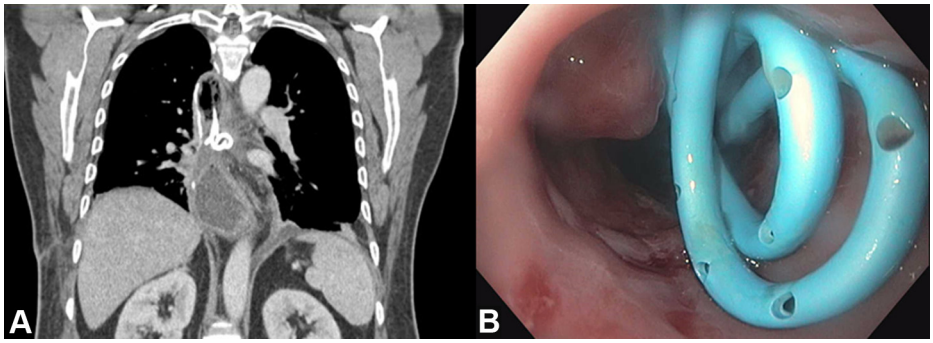

Fig. 1. A, coronal computed tomography image of two double pigtail stents between the mediastinal abscess and the gastric lumen. **B,** Endoscopic view of two double pigtail stents in the gastric lumen, distal to the anastomotic staple line.

A 61-year-old man with esophageal adenocarcinoma underwent minimally invasive esophagectomy and gastric pull-through. The initial postoperative course was without adverse events, and he was discharged home. However, on day 7 the patient was readmitted with fever, rapid atrial fibrillation, and leukocytosis. Chest CT scan revealed a 6.3 cm × 4.6 cm mediastinal abscess adjacent to the gastric pull-through (Fig. 1; Video 1, available online at www.giejournal.org). EUS-guided drainage was performed. The echoendoscope was positioned within the stomach, and the mediastinal collection was well visualized endosonographically. The abscess was punctured with a 19-G needle while Doppler flow imaging was used to avoid the mediastinal vessels. A 0.035-inch guidewire was coiled within the abscess. The tract was dilated with a 4.4F catheter. A double-lumen catheter was advanced over the guidewire into the collection. A second 0.035-inch guidewire was passed through the second lumen of the catheter to facilitate the placement of 2 wires within the mediastinal abscess. Two 7F × 5cm double pigtail catheters were then advanced over the wires and placed across the tract. The patient experienced rapid resolution of symptoms. He was afebrile and in normal sinus rhythm with downtrending white blood cell count the next day. A repeated CT scan in 4 weeks confirmed resolution of the abscess. Upper endoscopy was performed to remove the pigtail stents with a snare. EUS-guided drainage of a mediastinal abscess was safely performed. The small diameter of the stents prevented the need for large tract dilatation, which can be associated with bleeding. Successful stent placement, resolution of the collection, and stent removal was achieved over a 4-week period and avoided and prevented the need for repeated invasive surgery. The patient remains well at 3-month follow-up.

This video can be viewed directly from the GIE website or by using the QR code and your mobile device. Download a free QR code scanner by searching "QR Scanner" in your mobile device's app store.

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The following authors disclosed a financial relationship relevant to this publication: P. Saxena has received consulting fees from Boston Scientific and research support from Cook Medical. M. A. Khashab is a consultant for Boston Scientific and Olympus America and has

received research support from Cook Medical. The other author disclosed no financial relationships relevant to this publication.

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http://dx.doi.org/10.1016/j.gie.2013.12.026

Choledochoscopic surveillance in a patient with hepaticolithiasis

Figure 1. Dysplastic nodule.

A 54-year-old Asian woman with recurrent hepaticolithiasis had previously undergone a Kasai procedure (hepaticojejunostomy) and trisegmentectomy. The patient had a hepaticocutaneous jejunostomy after conventional surgery to allow atraumatic transcutaneous access to the biliary system for the removal of recurrent stones. A regular upper endoscope was used to access the biliary system and to clear the duct of stones every 3 to 4 months. Along with stone removal, a careful survey of the ducts was performed each time. During one of these choledochoscopies, nodular mucosa was noted in 2 areas of the left hepatic duct system. Biopsy samples revealed biliary duct dysplasia (Fig. 1; Video 1, available online at www.giejournal.org).

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Although rare, hepaticolithiasis-associated cholangiocarcinoma is a well-known entity; however, the surveillance pattern in hepaticolithiasis patients is not described. We demonstrate successful use of choledochoscopy as a potential surveillance tool, especially in patients with easy access to the biliary system, like our patient. We further propose that patients with recurrent stones postsurgery could be deemed high risk, and surveillance must be strongly considered in them to decrease future risk of cholangiocarcinoma. The treatment options for this condition may include argon plasma coagulation, EMR, or photodynamic therapy. Intraductal EUS is yet another modality that could be used in the management. In our patient, these lesions were small enough and were successfully