Long-term balloon indwelling technique for the treatment of single benign biliary stricture

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ABSTRACT
We aimed to evaluate the feasibility and safety of long-term balloon indwelling technique for the treatment of single benign biliary stricture. Five patients with single benign biliary stricture were included from December 2014 to November 2016. The patients were three men and two women with a mean age of 50 years (range, 30–65 years). A balloon catheter was inserted into the drainage catheter and emerged through the side hole of the catheter so that the balloon and drainage catheters could be placed together at the stricture site. Follow-up fluoroscopic examination was performed at least once every 2 weeks to evaluate the adequacy of expansion and location of the balloon. The balloon was reinflated at each session, and then removed after an approximately two-month indwelling period. The catheters used were 10–16 French and the diameter of indwelling balloons were 4–8 mm. The primary technical and clinical success rates were 100%. Maintenance of the balloon location was achieved in 25 of 26 follow-up fluoroscopic examinations (mean, 5.2 times per patient) with a rate of 96.1%. The mean follow-up period after successful removal of the balloon was 542.2 days (range, 93–1042 days), and there were no recurrences in the five cases. The long-term balloon indwelling technique is a good way to induce maximal dilatation at the stricture site without large diameter skin and subcutaneous tract dilatation and can be successfully used for single benign biliary stricture.

Several long-term indwelling interventional treatments for benign biliary stricture have been developed. Choo et al. (1) proposed balloon dilatation and large profile catheter maintenance method for benign biliary stricture. However, this method has limitations in that dilatation of skin and subcutaneous tissues must be as large as the diameter of the catheter for sufficient dilatation at the benign biliary stricture site. Skin and subcutaneous tract dilatation is usually very painful for patients and requires multiple sessions for sufficient dilatation. Gwon et al. (2) presented a dual catheter placement technique. This method can dilate the stricture site to a wider diameter than the previous single large profile catheter maintenance method, but still requires large diameter subcutaneous tract dilatation.

In this study, we evaluated a long-term balloon indwelling technique that is able to induce larger diameter dilatation at the target benign biliary stricture site while performing smaller skin and subcutaneous dilatation than the previously described methods.

Technique

Patients
The institutional review board approved this retrospective study and waived informed consent. From December 2014 to November 2016, five single benign biliary stricture patients at our institution were treated with the long-term balloon indwelling technique. Patients were three men and two women with a mean age of 50 years (range, 30–65 years). The strictures of three cases were treated after removing combined intrahepatic duct stones, and the other two were not accompanied by stones.

The benign biliary stricture site and presumed cause of biliary stricture for each patient are summarized in Table 1. All patients had undergone percutaneous transhepatic biliary drainage (PTBD) procedure.
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The 0.035-inch guidewire (Radiofocus Guidewire, Terumo) and catheter (Impress, Merit medical) were used to pass through the benign biliary stricture site. Before inserting an internal drainage catheter (Multipurpose Drainage Catheter; Sungwon medical), dilatation of the stricture site was performed using balloon catheters (Mustang, Boston Scientific). Balloon dilatation was performed with a balloon size up to 10%–15% larger than the estimated diameter of the duct. After dilatation of the stricture site, drainage pigtail catheter with multiple side holes was inserted over the 0.035-inch guidewire through the stricture site for inducing internal biliary drainage. Then, a balloon catheter was inserted and allowed to escape through one of the side holes of the drainage catheter. The balloon was then inflated to the desired diameter at the target stricture site, which was 2 mm smaller than the diameter of the balloon catheter used for primary balloon dilatation. When balloon dilatation is performed, the fluid to be injected into the inflation port should be diluted 1:3 with contrast medium and normal saline. Injection of contrast agent without dilution into the inflation port of the balloon catheter can make deflation impossible due to hardening of the contrast agent. Because the balloon should be indwelled for a long time, the inflation port of the balloon catheter was locked using a one-way flow switch (FloSwitch HP, Boston Scientific), and a plaster was used to wrap the flow switch around the inflation port to minimize deflation. A Y-connector (Rotating Hemostatic Valve, Abbott) was used to hold the balloon and the drainage catheter together during the indwelling period, and the Y connector’s valve was turned to tighten. Then the drain catheter was sutured to the skin and fixed. The remaining balloon catheter on the outside of the Y connector was well rolled and attached to the skin during the indwelling period (Figs. 1 and 2).

We set up the follow-up protocol to call patients at least once every 2 weeks to evaluate the adequacy of expansion and location of the balloon catheter. The balloon was reinflated with some amount of saline at each follow-up session and removed after about 2 months of indwelling period. Blood chemistry, including serum bilirubin, alanine transaminase (ALT), aspartate aminotransferase (AST), and alkaline phosphatase level (ALP), was followed up for liver function testing. Clinical symptoms such as fever and pain were also evaluated during the follow-up period.

Evaluation

Primary technical success, maintenance of balloon location, removal success, and clinical success were evaluated. Primary technical success was defined as successful placement of balloon and catheter at the intended location of stricture site in the first procedure session. Successful removal of the balloon was also evaluated. Clinical success was defined as maintenance of normalized blood chemistry result and no evidence of patients’ symptom related to biliary obstruction until the end of indwelling period of 2 months. For evaluating clinical success or failure, leukocytosis, fever, chill, and elevation of blood chemistry data (bilirubin, ALT, AST, ALP) were evaluated.

After removal of the balloon catheter, the patient was routinely examined for signs of recurrence or abnormal blood chemistry through outpatient follow-up.

Results

Table 1 summarizes the patients’ clinical characteristics, primary technical success, maintenance of balloon location, removal success, clinical success, and follow-up results. In all five cases, the balloon and catheter were successfully positioned on the intended location of benign biliary stricture site in primary procedure session; therefore, the technical success rate was 100%

According to the follow-up protocol before balloon removal, every patient should undergo follow-up fluoroscopic examination at least once every 2 weeks. Three patients (patients 1, 2, and 5) received five follow-up tubograms, and one patient (patient 3) received four follow-up tubograms. The other patient (patient 4) received seven evaluations until the balloon was removed. A total of 26 follow-up fluoroscopic examinations were performed in five patients.

Displacement of balloon catheter was

Main points

• Treatment of benign biliary stricture requires the use of long-term indwelling treatment method.
• A long-term balloon indwelling technique is a good way to induce maximal dilatation at the stricture site without large diameter skin and subcutaneous tract dilatation and can be successfully used for single biliary strictures.
• This technique is able to induce larger diameter dilatation at the target benign biliary stricture site while performing smaller skin and subcutaneous dilatation than the previously described methods.
Table 1. Patients’ clinical characteristics, used devices, the primary technical success, maintenance of balloon location, removal success, clinical success, and follow-up results

| Patient No. | Sex | Age (y) | Presumed cause of biliary stricture | Stricture site | Length of stricture site (mm) | Diameter of catheter (F) | Diameter of indwelling balloon (mm) | Length of indwelling balloon (mm) | Technical success | Indwelling time (days) | Follow-up fluoroscopies after placing the balloon catheter | Displacement of balloon catheter on follow-up fluoroscopy | Successful removal of balloon catheter | Clinical success | Follow-up period after balloon removal (days) | Recurrence |
|------------|-----|---------|------------------------------------|---------------|-------------------------------|-------------------------|----------------------------------|-----------------------------------|-----------------|----------------------|-------------------------------|-------------------------------|-----------------------------|---------------|---------------------------------|-------------|-----------|
| 1          | F   | 50      | Recurrent choledolithiasis          | CBD           | 19                            | 10                      | 8                                | 40                                | Yes             | 64                   | 5                             | 1<sup>st</sup>                         | Yes                           | Yes                         | 106               | No                    |
| 2          | M   | 64      | PPPD with choledochocejunostomy d/t IPMN | CBD           | 11                            | 10                      | 6                                | 60                                | Yes             | 59                   | 5                             | 0                           | Yes                           | Yes                         | 1042              | No                    |
| 3<sup>rd</sup> | M  | 41     | Choledochojjunostomy d/t CBD injury during laparoscopic cholecystectomy | CBD           | 3                             | 16                      | 8                                | 60                                | Yes             | 57                   | 4                             | 0                           | Yes                           | Yes                         | 743               | No                    |
| 4<sup>th</sup> | F  | 30     | Choledochal cyst type 1 excision    | Hepatocojjunostomy site | 12                            | 10                      | 7                                | 40                                | Yes             | 86                   | 7                             | 0                           | Yes                           | Yes                         | 96                | No                    |
| 5          | M   | 65      | Anterior sectionectomy of the liver | Between right posterior segment IHD and CBD | 14                            | 10                      | 4                                | 20                                | Yes             | 56                   | 5                             | 0                           | Yes                           | Yes                         | 724               | No                    |

F: female; M: male; CBD: common bile duct; PPPD: pylorus preserving pancreaticoduodenectomy; IPMN: intraductal papillary mucinous neoplasm; IHD: intrahepatic duct.

* Prior percutaneous biliary stone removal had been performed.
* Balloon displacement was detected at one of five total follow-up fluoroscopies and immediately adjusted to the right position.
* Prior percutaneous biliary stone removal had been performed with 16 F catheter and we continued to use that catheter for long-term balloon indwelling technique.

Discussion

Treatment of benign biliary stricture is controversial. Various interventional radiological treatment methods have been developed. Balloon dilatation methods have been used clinically. Percutaneous balloon dilatation followed by PTBD was not performed because there were no references in any of the five cases in terms of laboratory findings and clinical symptoms.

The mean follow-up period after successful balloon dilatation was 93.1±142 days, and there were no recurrence or adverse symptoms or abnormal laboratory findings during the follow-up period. However, 100% of the patients (5/5) achieved clinical success. No adverse symptoms or abnormal laboratory findings were detected at only 1 of 26 follow-up fluoroscopic examinations. No recurrence or adverse symptoms or abnormal laboratory findings were detected at only 1 of 26 follow-up fluoroscopic examinations. No recurrence or adverse symptoms or abnormal laboratory findings were detected at only 1 of 26 follow-up fluoroscopic examinations.
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catheter (Fig. 1), which is usually about 10 F. Because of these procedural benefits, we believe that this technique has important advantages in pain management and treatment effectiveness of the stricture site.

Table 2 summarizes the ease of balloon catheter passage according to the diameter of the drainage catheter. In general, 10 F drainage catheters can easily accept the 10 mm balloon catheter. In this study, there was 1 patient using a 16 F drainage catheter. In that case, tract dilatation was required to remove the combined intrahepatic biliary stone, and the long-term balloon indwelling technique was performed.

However, now we think that this technique can only be applied to single benign biliary strictures. We may use a long balloon catheter to induce a therapeutic effect on multiple stricture sites, but the balloon catheter may have an unintended effect of blocking multiple hepatic biliary ducts that would need to drain internally through the multiple side holes of the drainage catheter.

There were several limitations in this study. First, this study design was retrospective. Second, there was no comparative arm. Third, the number of patients enrolled in this study was small, and additional studies and more cases are needed to further assess the feasibility of this method.

In conclusion, a long-term balloon indwelling technique is a good way to induce maximal dilatation at the stricture site with- out large diameter skin and subcutaneous tract dilatation and can be successfully used for single biliary stricture.

Conflict of interest disclosure
The authors declared no conflicts of interest.

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