

Coiled ERCP Catheter In The Oral Cavity

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Citation

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Abstract

We report a case of coiled nasobiliary tube in a patient posted for open cholecystectomy with CBD exploration to highlight that such patient should be reevaluated on the operation table prior to induction to rule out any overnight migration and coiling of such catheters in the oral cavity. Like in this case if, we had done repeat oral cavity examination prior to induction, the coiled ERCP catheter could have been detected in oral cavity.

CASE REPORT

ERCP is indicated for Endoscopic sphincterotomy in Choledocholithiasis, Jaundice thought to be the result of biliary obstruction, Stent placement across benign or malignant strictures, fistulae, postoperative bile leak, or large common bile duct stones Balloon dilatation of ductal strictures, Nasobiliary drain placement

A Thirty-two years old female having a stone in common bile duct was scheduled to undergo open cholecystectomy with CBD exploration. She had been admitted in surgical ward for over 15 days. On admission she had serum bilirubin 16.5 gm%, prothrombin time 18 seconds and INR 1.46. Her Serum alkaline phosphate was 1930 IU. Ultrasonography of abdomen showed multiple calculi in gall bladder and dilated CBD having more than 1.5 cm size calculus. It was planned to do Endoscopic retrograde cholecystopancreatography (ERCP) for stone removal in CBD and bile drainage. ERCP was done under midazolam sedation. Deep cannulation was carried out with a 7 french G ERCP catheter. A large stone (>2 cm) in the middle of common bile duct was revealed. It was decided to remove the stone surgically in view of its big size. ERCP catheter was left in situ for drainage of bile and to guide CBD during surgery. Her bilirubin had dropped from 16.5 to 4.5 gm%, PT to 14 sec and INR to 1.0 with normal alkaline phosphatase following ERCP drainage. Day before surgery a through Preanaesthetic checkup was done. Proper airway examination was carried out, ERCP catheter was seen passing through the posterior pharyngeal wall. A rapid sequence induction was done with Propofol and Succinylcholine to facilitate endotracheal intubation in view of in situ ERCP catheter related decrease in lower oesophageal sphincter tone to prevent regurgitation .While

doing mask ventilation resistance was encountered in reservoir bag. When laryngoscopy was done it revealed coiled ERCP catheter (around 10 cm) in oral cavity (Fig. 1).

Figure 1

Figure 1: Nasobiliary tube (green colored tube) coiled up in the oral cavity.



It was pushed to one side by magill forceps and endotracheal intubation was carried out. Intraoperatively distal tip of catheter was in CBD only and 100 ml of biliary fluid was aspirated by suction. After the stone removal, the catheter was removed and nasogastric tube was inserted. Around 60 ml of biliary fluid was quickly drained from nasogastric tube. When enquired from the ward nurse, she admitted that there had been very little bile drainage since previous evening. At the end of surgery, the patient was reversed uneventfully. We were fortunate enough that the patient did not regurgitate as lot of biliary fluid came out after putting nasogastric tube as coiling of ERCP catheter was hampering its outflow.

This case serve to highlights that such patient should be re-evaluated on the operation table prior to induction to rule out any overnight migration and coiling of such catheters in the oral cavity. Like in this case if, we had done repeat oral cavity examination prior to induction, the coiled ERCP catheter could have been detected in oral cavity.

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