Vidéo session

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- Patiente âgée de 56 ans.
- Terrain : cholécystectomie.
- Clinique: Sd cholédocien.
- Bili IRM: lithiase de 8mm de la VBP obstructive avec une dilatation en amont de 15mm.
- Procédure: CPRE/SE, extraction de calcul à la Dormia.

- 02h après douleurs abdominales intenses, faisant suspecter une perforation digestive confirmer par le CT.
- Malade repris avec un latéroscope pour gérer la perforation.

RECOMMENDATION

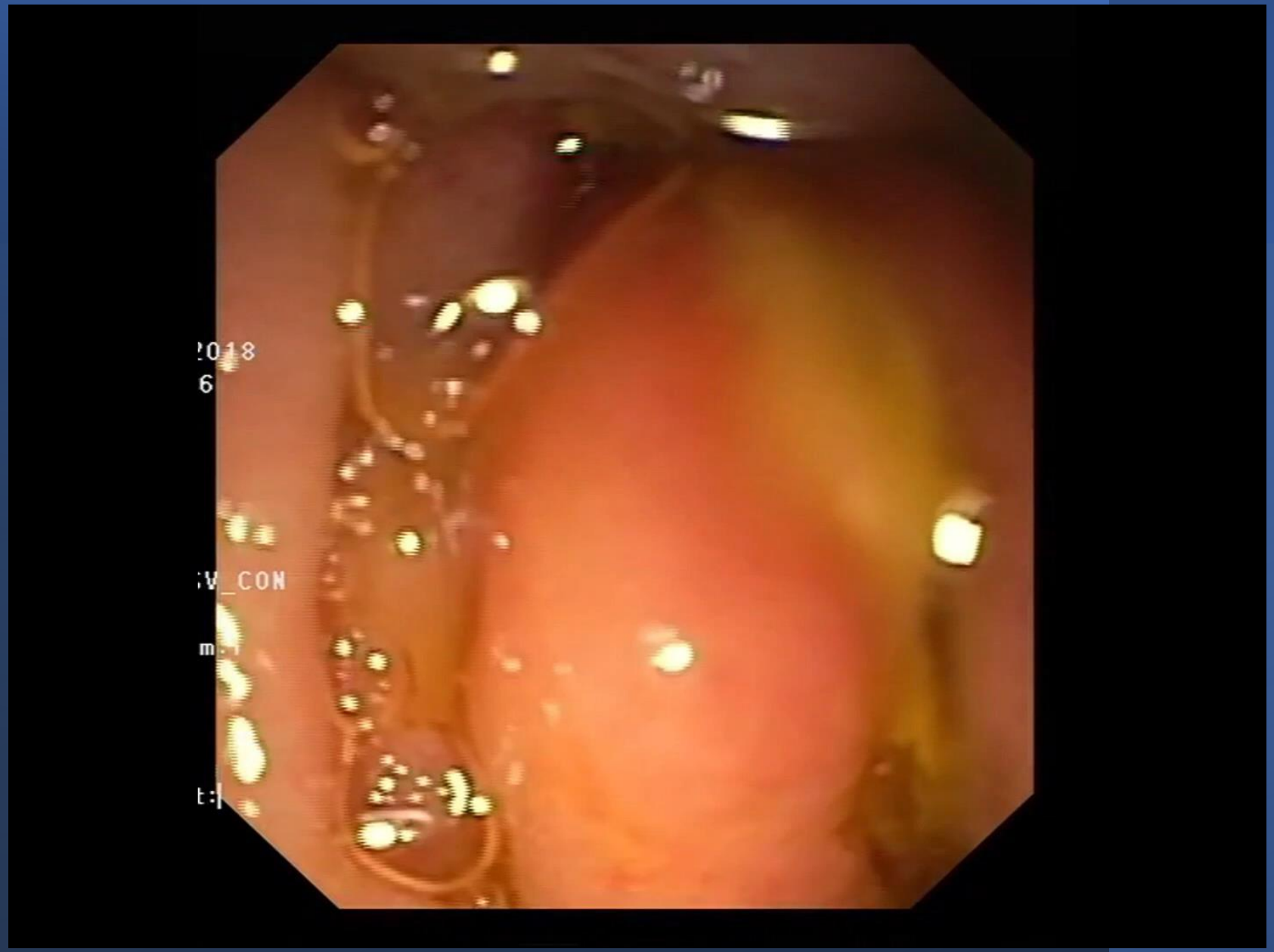
ESGE recommends that symptoms or signs suggestive of iatrogenic perforation after an endoscopic procedure should be rapidly and carefully evaluated and documented with a CT scan.

RECOMMENDATION

ESGE recommends that endoscopic closure should be considered depending on the type of the iatrogenic perforation, its size, and the endoscopist expertise available at the center. Switch to carbon dioxide (CO2) endoscopic insufflation, diversion of digestive luminal content, and decompression of tension pneumoperitoneum or pneumothorax should also be performed.

Table 4s. Types of ERCP-related perforations according to Stapfer et al [19]

Type	Description	Frequency
I	Duodenal wall perforation (by the endoscope)	18%
II	Periampullary perforation (by sphincterotomy/precut)	58%
III	Biliary or pancreatic duct perforation (by intraductal instrumentation)	13%
IV	Retroperitoneal gas alone	11%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RECOMMENDATION

ESGE suggests nonsurgical management in the majority of ERCP-related periampullary or biliopancreatic ductal iatrogenic perforations. The indications for surgery include a major contrast medium leak, severe sepsis despite nonsurgical management, severe peritonitis, and fluid collections or unsolved problems (e.g., retained hardware) that cannot be solved by nonsurgical means.

Merci