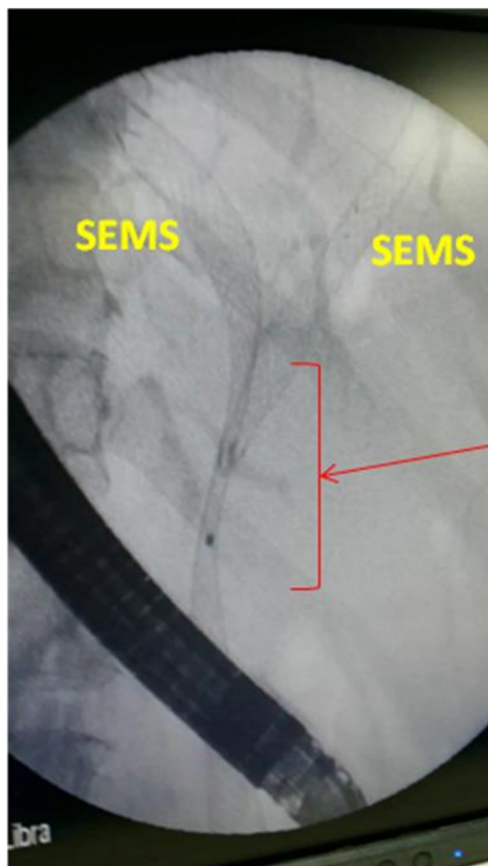
Mr M K B 51 years old male admitted with history of jaundice and pruritus for one and half month. He gave history of occasional intermittent fever for initial 10 days. He lost around 10 kg weigh over 2 months. His serum Bilirubin was 25mg/dl with conjugated fraction of 22 mg/dl, alkaline phosphatase OF 725 IU/L, normal SGPT & SGOT, serum albumin 3.2 gm/dl. Ultrasonography of abdomen revealed dilated intrahepatic biliary radicles and both hepatic ducts. Serum CA 19-9 was 365 U/ml. Triple phase CECT abdomen showed illdefined heterogeneously enhancing lobulated mass lesion seen obstructing the common hepatic duct (CHD) leading to upstream dilatation of biliary radicles and few hepatogastric and aortocaval lymphnodes. MRCP showed irregular soft tissue lesion at CHD with hllar involvement. After discussion with oncosurgeon and oncologist, was planned for ERCP with metallic stent placement. ERCP was done on Oct 2013. Selective biliary cannulation was done. Bile aspirates and brush cytology from CHD stricture send for microscopic examination for malignant cell. Bile also was send for C/S. Cholangiogram showed involvement of CHD and hilum with separation of both hepatic ducts. Both hepatic ducts were accessed separately. Saline wash was done under aseptic precaution. In view of separated both hepatic ducts and drainage pus during procedure we decided to stent both system at time of procedure. One 8 cm self expanding metallic stent (SEMS) was placed in right hepatic duct across stricture into duodenum. Another 6 cm SEMS was placed in left hepatic duct across stricture with lower end at CHD.

Bile cytology and brush cytology were positive for malignant cell and suggestive of adenocarcinoma. Patient received chemotherapy later on.



Hilar stricture area (area of cholangiocarcinoma) with bilateral metal stent in situ