Pancreatic Stricture Management

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Objectives

• Describe different types/variables of pancreatic duct strictures
• Describe endoscopic management of Pancreatic Duct Strictures
Disclosures

• None
Types

- Malignant Stricture
- Benign Strictures
  - Chronic Pancreatitis:
    - Inflammation
    - Fibrosis
  - At the surgical anastomosis after pancreatic surgery
Presentation

• Asymptomatic
• Symptomatic
  • Pain
  • Acute on Chronic Pancreatitis
Workup

• Imaging (CT, MRI/MRCP)
• Oral EUS: Rule out malignant stricture, PD stone
• ERCP: Brushing, Biopsy, Confocal laser endomicroscopy
Endoscopic Management

• PD stricture are usually tight and resilient
• Dilation alone: Not recommended
• Dilation + stenting (for non-PD stone related strictures)
Effectiveness of Dilation + Stents

- Pain improvement 65-84%
- Long term effectiveness: symptomatic improvement may persist after stent removal even if the stricture persists

Single vs Multiple Stents

• PD plastic stents are prone for occlusion
• If using a single stent place a 10 Fr across the stricture over a single small stent
• Single small stents associated with increase risk of abdominal pain resulting in hospital admission
• Most favor multiple small stents (avoid blockage of pancreatic side branches)

Dumonceau JM et al Endoscopy 2012;44:784-800.
Multiple Stents

- A single small series
- Median of 3 stents
- Permitted 84% of the cohort to achieve persistent pain relief after a mean follow-up of 38 months

Post-Operative Anastomotic Stricture

• Challenges in ERP
  • Altered anatomy: Afferent limb identification and intubation
  • PJ identification
  • PJ cannulation

• Role of EUS
  • Etiology of PJ stricture: tumor recurrence vs benign
  • Drainage: Rendez-vous vs direct drainage
Presentation

• Pain
• Pancreatitis
• Dilated PD
Management PJ strictures

• Dilation
• Stenting