Surgical management of the cases with both biliary and duodenal obstruction

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A B S T R A C T

Endoscopic management is presently the recommended first-line of treatment for biliary strictures. However, surgery still has an important role especially for biliary obstruction (BO) with duodenal obstruction. Even though endoscopic treatment for concurrent BO and gastric-outlet obstruction has been proposed, it is still not widespread. Duodenal obstruction is often associated with malignant BO which makes endoscopic treatment more challenging. Biliary and gastrointestinal double bypass with Roux-en-Y hepatojejunostomy and gastrojejunostomy is the most common surgical intervention for malignant biliary and gastric-outlet obstruction. A variety of procedures of biliary bypass and gastrointestinal bypass have been reported. According to several studies, mortality rates range from 0% to 7%, while morbidity rates range from 3% to 50%. Higher morbidity was observed in symptomatic patients caused by the disease. Most common morbidity after double bypass was delayed gastric emptying. Recurrence of BO and gastric-outlet obstruction was less frequently seen after surgical bypass compared to after endoscopic treatment. Minimally invasive approach has been applied to double bypass. Studies showed that laparoscopic double bypass has a shorter hospital stay and reduced postoperative pain; however, due to its technical demand, it is still presently an uncommon procedure. Robotic bypass surgery may resolve this issue in the future. Further analyses of outcomes of both surgical and endoscopic treatments are necessary to establish better and suitable palliation options for concurrent biliary and duodenal obstruction caused by unresectable malignant tumors.

Keywords: Cholestasis; Duodenal obstruction; Surgical procedures, operative

Introduction

Although endoscopic management has replaced the role of surgery in the treatment of biliary strictures in the recent years, surgical intervention is still a reliable option particularly for biliary obstruction (BO) with duodenal obstruction. Malignancy in the periampullary region, including pancreatic cancer, often leads not only BO but gastric-outlet obstruction (GOO) due to duodenal involvement. Endoscopic transpapillary stenting for BO is less invasive and thus, became the preferred choice of treatment for malignant BO. However, it is more challenging when there is a concurrent duodenal obstruction present. Although endoscopic treatment for concurrent BO and GOO has been proposed, it is technically demanding and, therefore, performed only in highly specialized centers.1–3

The most effective solution for concurrent BO and GOO due to malignancy is surgical resection of the lesion. However, periampullary malignancy, especially pancreatic head cancer, is frequently discovered as an unresectable tumor due to locally advanced or metastatic disease. A systematic review of comparative studies of R2 resection and bypass for pancreatic cancer revealed that R2 resection was associated with increased morbidity and mortality rates without improving survival.4 Therefore, biliary and gastrointestinal double bypass is usually performed as a surgical palliation for concurrent BO and GOO. While endoscopic biliary metal stent is described as a preferred method for BO alone due to unresectable pancreatic cancer in the National Comprehensive Cancer Network guidelines, open or laparoscopic gastrojejunostomy is recommended for GOO alone of patients with good performance status.5 Although there is no description of recommended treatment for concurrent BO and GOO in the guidelines, it is empirically realized that surgical bypass plays an important role in...
Surgical Procedures

Double bypass for concurrent BO and GOO consists of biliary-enteric and gastro-enteric anastomosis. For biliary-enteric anastomosis, Roux-en-Y hepaticojejunostomy is commonly performed. In some cases, hepaticoduodenostomy, choledochojejunostomy, choledochoduodenostomy, cholecystojejunostomy and cholecystoduodenostomy can also be acceptable options. Based on our previous study, we also utilize hepaticocholecystojejunostomy for biliary-enteric anastomosis in selected cases (Fig. 1, 2). For gastro-enteric anastomosis, side-to-side gastrojejunostomy is the most common procedure. Some surgeons favor anastomosing the stomach to the efferent limb at the distal side of the biliary-enteric anastomosis (Fig. 1), while others anastomose the stomach to the afferent limb. The location of gastrojejunostomy is either the ventral side (anecolic) or the dorsal side (retrocolic) of the transverse colon. When gastrojejunostomy is in the anecolic position, side-to-side jejunojejunalostomy (Braun’s anastomosis) is often added. Partial stomach-partitioning is sometimes added to gastrojejunostomy (modified Devine procedure) (Fig. 3). A meta-analysis of retrospective studies showed partial stomach-partitioning significantly decreased the risk of delayed gastric emptying (DGE) after gastrojejunostomy for malignant GOO although the mechanism has not been elucidated yet.

Outcomes

Table 1 shows outcomes of biliary and gastrointestinal double bypass from the literature. Among the 14 studies, two were prospective randomized controlled trials (RCTs) comparing double bypass and biliary bypass alone, eight studies were retrospective comparative studies and the remaining were case series.
Perioperative outcomes

Operative time was available in seven studies.\(^6,9,14,16,18–20\) Double bypass was significantly longer than exploration laparotomy or single bypass, but shorter than pancreaticoduodenectomy.\(^14,16,18–20\) Mortality rates ranged from 0\% to 7\%, and morbidity rates ranged from 3\% to 50\%.\(^6,7,9,10,14–22\) The morbidity rates were relatively high probably because the preoperative condition of a symptomatic patient is usually suboptimal due to medical problems caused by the disease (i.e., jaundice secondary to BO, undernourishment secondary to GOO). Furthermore, our analysis showed that prophylactic double bypass performed for unresectable pancreatic cancer patients without symptoms of BO and GOO was associated with lower morbidity rate (3\%).\(^9\) It was reported that GOO and lack of biliary stent were independent risk factors of postoperative morbidity.\(^6,7,9,10\) Laparoscopic double bypass performed for unresectable pancreatic cancer patients without symptoms of BO and GOO was associated with lower morbidity rate (3\%).\(^6,7,9,10\) However, the postoperative morbidity rate ranges from 0\% to 4.8\%.\(^6,7,9,10,14,15,22\) In addition, Hamada et al\(^2\) described the first laparoscopic double bypass with hepaticojejunostomy. In this study, they compared laparoscopic bypass cases with matched open bypass cases; results showed that laparoscopic bypass significantly decrease duration of hospital stay and reduce morphine use. Despite of the benefits of laparoscopic surgery in terms of postoperative pain, which may translates to enhanced patient recovery, laparoscopic double bypass is still an uncommon procedure. First, laparoscopic hepaticojejunostomy is technically difficult\(^15\); it requires suturing in the hepatic portal area, wherein manipulation of instruments is limited. Second, failure in suturing causes complications such as bile leak or biliary stenosis which rate ranges from 0\% to 4.8\%.\(^6,7,9,10,14,15,22\) Minimally invasive biliary and gastrointestinal double bypass was first reported in 1992.\(^26\) In the same year, a report on laparoscopic gastroenterostomy for malignant GOO was also published.\(^14,15\) Median survival time after double bypass ranges from 6 to 14.6 months.

Long-term outcomes

Five studies revealed that incidence of recurrence of BO ranges from 0\% to 5\%.\(^5,9,10,22\) On the other hand, recurrence rate of after endoscopic treatment for malignant BO with duodenal obstruction was 34\%.\(^5\) Meta-analyses of studies comparing endoscopy and surgery for malignant BO revealed that recurrence of BO was significantly less in biliary bypass compared to biliary stent.\(^14,25\) With regards to GOO recurrence, studies showed that incidence

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>No. of patients</th>
<th>Procedure</th>
<th>Operative time (min)</th>
<th>Mortality (%)</th>
<th>Morbidity (%)</th>
<th>Hospital stay (day)</th>
<th>Recurrence of BO (%)</th>
<th>Recurrence of GOO (%)</th>
<th>Prognosis (mo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lillemoe et al(^15) (1999)</td>
<td>44</td>
<td>HJ + GJ</td>
<td>254 (mean)</td>
<td>0</td>
<td>32</td>
<td>8.5 (mean)</td>
<td>NA</td>
<td>0</td>
<td>8.2 (mean)</td>
</tr>
<tr>
<td>Van Heek et al(^15) (2003)</td>
<td>36</td>
<td>HJ + GJ</td>
<td>NA</td>
<td>3</td>
<td>31</td>
<td>11 (median)</td>
<td>NA</td>
<td>2.8</td>
<td>7.2 (MST)</td>
</tr>
<tr>
<td>Lesurtel et al(^6) (2006)</td>
<td>83</td>
<td>HD or HJ + GJ</td>
<td>203 (mean)</td>
<td>4.8</td>
<td>27</td>
<td>16 (median)</td>
<td>1.2</td>
<td>4.8</td>
<td>9.2 (MST)</td>
</tr>
<tr>
<td>Schniewind et al(^5) (2006)</td>
<td>129</td>
<td>HJ + GJ</td>
<td>246 (mean)</td>
<td>2.6</td>
<td>42</td>
<td>15 (mean)</td>
<td>NA</td>
<td>NA</td>
<td>6 (MST)</td>
</tr>
<tr>
<td>Fusi et al(^15) (2008)</td>
<td>39</td>
<td>BE + GJ</td>
<td>NA</td>
<td>3.1</td>
<td>31.1</td>
<td>11 (median)</td>
<td>NA</td>
<td>9</td>
<td>(MST)</td>
</tr>
<tr>
<td>Mann et al(^15) (2009)</td>
<td>102</td>
<td>HJ + GJ</td>
<td>NA</td>
<td>5.9</td>
<td>26.7</td>
<td>12 (median)</td>
<td>2</td>
<td>2</td>
<td>9.5 (MST)</td>
</tr>
<tr>
<td>Bockhorn et al(^15) (2009)</td>
<td>40</td>
<td>HJ + GJ</td>
<td>140 (median)</td>
<td>5</td>
<td>18</td>
<td>17 (median)</td>
<td>NA</td>
<td>NA</td>
<td>7.5 (MST)</td>
</tr>
<tr>
<td>Walter et al(^10) (2011)</td>
<td>154</td>
<td>HJ + GJ</td>
<td>261 (mean)</td>
<td>3.9</td>
<td>38</td>
<td>17 (mean)</td>
<td>NA</td>
<td>NA</td>
<td>6 (MST)</td>
</tr>
<tr>
<td>Lyons et al(^12) (2012)</td>
<td>60</td>
<td>HJ, CJ, HD, CD or CCJ + GJ</td>
<td>NA</td>
<td>3</td>
<td>15</td>
<td>NA</td>
<td>5</td>
<td>2</td>
<td>NA</td>
</tr>
<tr>
<td>Ausania et al(^11) (2012)</td>
<td>50</td>
<td>HJ + GJ</td>
<td>NA</td>
<td>4</td>
<td>50</td>
<td>12.6 (median)</td>
<td>NA</td>
<td>NA</td>
<td>14.6 (MST)</td>
</tr>
<tr>
<td>Ueda et al(^14) (2014)</td>
<td>69</td>
<td>HCJ or HJ + GJ</td>
<td>NA</td>
<td>0</td>
<td>15</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Tol et al(^4) (2015)</td>
<td>203</td>
<td>HJ + GJ</td>
<td>NA</td>
<td>2</td>
<td>18</td>
<td>9 (median)</td>
<td>NA</td>
<td>NA</td>
<td>9 (MST)</td>
</tr>
<tr>
<td>Insulander et al(^16) (2014)</td>
<td>74</td>
<td>HJ + GJ</td>
<td>169 (median)</td>
<td>7</td>
<td>35*</td>
<td>9 (median)</td>
<td>NA</td>
<td>NA</td>
<td>7.2 (MST)</td>
</tr>
<tr>
<td>Miyasaka et al(^17) (2017)</td>
<td>32</td>
<td>HCJ, HJ or CCJ + GJ</td>
<td>272 (median)</td>
<td>0</td>
<td>3</td>
<td>18 (median)</td>
<td>0</td>
<td>0</td>
<td>11 (MST)</td>
</tr>
</tbody>
</table>

HJ, hepaticojejunostomy; GJ, gastrojejunostomy; HD, hepaticoduodenostomy; BE, bilo-enterostomy; CJ, choledochojejunostomy; CD, choledochoduodenostomy; CCJ, cholecystojejunostomy; HCJ, hepaticocholecystojejunostomy; NA, not available; BO, biliary obstruction; GOO, gastric-outlet obstruction; MST, median survival time.

\(^a\)Clavien Dindo grade IIIa.

Table 1 Outcomes of Biliary and Gastrointestinal Double Bypass
delay introduction of systemic chemotherapy. Hence, cholecystojejunoanastomosis is a more favored procedure for laparoscopic biliary bypass since cholecysto-jejunal anastomosis is technically easier. However, it is not useful for cases with occluded cystic duct.

Development of robotic surgery has made intracorporeal suturing easier. Lai and Tang reported 9 cases of robot-assisted laparoscopic bypass, of which 5 cases had hepaticojejunoanastomosis and 4 cases had double bypass, with favorable perioperative outcomes. Robotic surgery may remedy the limitations of laparoscopic bypass and may possibly enhance recovery of patients who need double bypass for concurrent BO and GOO.

**Conclusion**

Although endoscopic palliation has become mainstream treatment for BO, surgical bypass still plays an important role in the management of concurrent BO and GOO for selected patients. Recent development of new chemotherapeutic regimens have improved the prognosis of patients with unresectable peripancreatic cancer. It demands long-lasting palliation of BO and GOO. In terms of surgery, double bypass should be considered as an option for patients with good performance status. Furthermore, prophylactic bypass for asymptomatic patients with unresectable tumors have better outcomes. In terms of approach, minimally invasive surgery reduces postoperative pain and length of hospital stay but have better outcomes. In terms of approach, minimally invasive surgery reduces postoperative pain and length of hospital stay but have better outcomes. Robotic surgery may remedy the limitations of laparoscopic surgery in the future.

Tailoring the ideal palliative treatment in patients can reduce unnecessary procedures and morbidity that may delay the induction and reduce the efficacy of chemotherapy. In addition, further analyses of outcomes of both surgical and endoscopic treatment, including RCTs, are necessary to establish better and suitable palliation options for concurrent biliary and duodenal obstruction due to unresectable malignant tumors.

**Conflicts of Interest**

No potential conflict of interest relevant to this article was reported.

**References**


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