Palliation of malignant hilar obstruction at a single centre – review of operative and non-operative techniques

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Summary

Introduction. Jaundice secondary to a malignant hilar obstruction can be relieved by operative bypass or percutaneous stenting. Comparative trials involving these techniques are scarce. We reviewed our experience with these competing techniques in the palliation of malignant hilar obstruction.

Patients and methods. All patients with malignant hilar obstruction managed at our institution during the period 1992 - 2002 were identified for review.

Results. A total of 36 deeply jaundiced patients with hilar obstruction were identified. Twenty-two patients underwent exploration with the intention of performing an operative bypass and 14 patients underwent percutaneous transhepatic cholangiography (PTC) with intention to stent. Procedure-related mortality was similar in both groups. Morbidity was much higher in the operative group. Effective symptom relief was achieved with both techniques. In the PTC group recurrent biliary obstruction in 2 patients necessitated salvage non-operative procedures. Although survival rates were slightly longer in the operative group, this was not significant. There were no long-term survivors.

Conclusion. Operative bypass provides better sustained relief of jaundice than PTC. However long-term survival in both groups is poor and operative bypass is best reserved for younger patients with no technical contraindications. Despite early and late procedural failures PTC is the method of choice for patients with advanced-stage disease and those with significant co-morbidities.

Only a small subset of patients with malignant hilar obstruction may be candidates for resectional surgery and for the majority palliation of jaundice is the therapeutic objective.1-6 The gold standard in palliation is a widely patent biliary-enteric anastomosis, above the level of obstruction. For patients with a proximal obstruction, this involves the fashioning of an intrahepatic biliary-enteric anastomosis.7-19 However, in patients with advanced malignancy and jaundice major abdominal surgery carries risk.20-23 The endoscopic or percutaneous deployment of stents across the obstruction has increasingly been used as an alternative to operative bypass.24-27 The first stents were plastic and narrow-gauge and recurrent occlusion necessitated further procedures, thus impacting negatively on the quality of palliation.23 Modern self-expanding metal wall stents provide more durable relief of jaundice.23,24,26,27 We reviewed our experience with the management of malignant hilar obstruction over the period 1992 - 2002 in an attempt to clarify the roles of operative and non-operative bypass. This period encompassed the era of operative bypass and the advent of the percutaneous metal wallstent insertion at our institution.

Patients and methods

We reviewed all patients who had presented to us with malignant hilar obstruction between 1992 and 2002 and who were treated with either a biliary enteric bypass or a wallstent. Notes were retrieved from the hospital records and proformas were filled out documenting routine demographic details, modality of treatment complications and survival.

Operative bypass

We used the technique initially described by Soupault and Couinaud7 in 1957 which involves the anastomosis of a jejunal loop to the segment III duct on the left side of the liver.
The operation relies on the anatomical understanding that the obliterated umbilical vein which runs in the ligamentum teres joins the segment III branch of the portal vein. The accompanying bile duct lies above and behind this corresponding portal venous radical. Downward traction to the right on the divided ligamentum teres allows for finger and diathermy fracture of the parenchyma between segments III and IV (Fig. 1). This creates a wedge-shaped space leading down to the segment III duct (Fig. 2). The bile duct is located by needle aspiration and is exposed for 2 cm. It is opened longitudinally for at least 1 cm and a Roux-en-Y loop is anastomosed end-to-side or side-to-side depending on the best fit in the confined space using a fine interrupted absorbable suture material (Fig. 3). A transanastomotic stent is left in place depending on the operator’s discretion. This allows for postoperative cholangiography and is removed 2 weeks after the operation.

Percutaneous transhepatic cholangiography (PTC)

With the patient cleaned and draped, a puncture site is fluoroscopically selected below the costophrenic angle in the mid-axillary line. A 22-gauge Chiba needle is advanced towards a marker placed on the xiphisternum, and contrast is injected as the cannula is withdrawn. Once ductal entry is confirmed the biliary tree is opacified and a definite point of entry identified. The system is re-cannulated and a guide wire is passed into the system and manipulated across the stricture into the duodenum. The tract is dilated prior to the self-expanding metal stent being delivered, with the distal end in the duodenum and the proximal end sitting in a peripheral biliary radicle. Once the position is confirmed, the stent is deployed.

Results

A total of 36 deeply jaundiced patients with hilar obstruction were treated at our institution during the period under review. Their age range was 46 - 89 years and the average serum bilirubin level was 251 µmol/l (range 105 - 407 µmol/l). During the period 1992 - 1998, 22 patients underwent exploration with the intention of performing a segment III duct cholangioenteric anastomosis. Since 1998 no patient has undergone an operative segment III bypass. One patient had undergone a prior attempt at endoscopic stenting. Two patients (9%) died peri-operatively. One patient with liver cirrhosis died from coagulopathic bleeding and 1 from a myocardial infarction. Three patients (14%) developed biliary fistula, 1 of which persisted until the patient’s death. Twenty patients were discharged home. The bilirubin level fell significantly from 243 µmol/l (± 114) to 95 (± 47) µmol/l 2 weeks after surgery ($p < 0.0003$) in all patients. Pruritus was relieved in all patients. Eight patients (36%) remained jaundice free until death at 1, 3, 6, 6, 8, 9, 9 and 11 months following surgery. Twelve patients were still alive after a year. Ten (83%) of these were anicteric after a year. Only 4 returned for review after 1 year. All of this group have subsequently died. The longest survivor lived for 28 months.
Between 1995 and 2002 14 patients (age range 53 - 78 years) underwent PTC with the intention to stent. Their diagnosis included cholangiocarcinoma (N = 10), hepatoma (N = 1), and gallbladder carcinoma (N = 3). Non-therapeutic exploration (N = 2), unsuccessful cholecystjejunostomy (N = 1) and failed endoscopic stent placement (N = 1) were performed before referral. Three were in established renal failure at presentation. PTC was successful at a single sitting in 9 patients, and at multiple sittings in 3. In 2 PTC was unsuccessful. These patients were left with external biliary fistulas (14%). In all patients who had undergone successful PTC, serum bilirubin levels dropped significantly by 1 week (84 µmmol, p < 0.003). All these patients experienced relief of pruritus. Renal failure resolved in the 3 patients who had presented with this established complication. Two patients (14%) died during the index hospital admission. Recurrent biliary obstruction in 2 patients (14%) necessitated salvage endoscopic retrograde cholangiopancreatography (ERCP) and PTC respectively. Three were transferred back to their referral hospital. Four patients survived more than a year. The remaining patients died as outpatients, with a median survival of 7 months. Figs 4 and 5 show the PTC of a patient demonstrating short hilar stricture with a failed endoscopic stent in situ. An overlapping stent was deployed percutaneously to alleviate the obstruction.

Discussion

The literature reporting on the operative palliation of malignant hilar obstruction is summarised in Table I and that reporting on the non-operative palliation is summarised in Table II. There are several consistent features in these series. As in our study, the numbers are generally small, the long-term survivors are few, and there is a paucity of quality-of-life data. Histological data are similarly vague as it is often difficult to obtain decent histological specimens in the setting of biliary malignancy. Most series include a number of diverse pathologies such as Klatskin tumours, gallbladder carcinomas and external compression from malignant hilar lymph nodes.

Our results with operative bypass are in keeping with the literature and confirm that the operation is technically feasible and successful in providing symptom relief until death, although it is associated with a not inconsiderable mortality and morbidity.9,11,15,28,29 Survival is limited to less than a year in all series including our own. In our non-operative group significant numbers presented with established renal failure (N = 3) and prior intervention (N = 4). We feel that this has contributed to our relatively high morbidity and mortality and technical failure rate with this procedure. We would expect a much higher primary success rate in patients who did not have an established complication of obstructive jaundice and who had not undergone unsuccessful invasive interventions before referral.

Decision-making in this group of patients is difficult. They have advanced malignancy, limited life expectancy and are at risk of developing several life-threatening complications. It is essential that the treatment modality has negligible morbidity and mortality and provides sustained relief of jaundice until death. Choosing the most appropriate palliative approach for an individual patient must take into account the patient's expected remaining life expectancy and systemic fitness.3,5,6,22,25-27,30 The objection to non-operative palliation advanced by Myburgh18 was that it was not as durable a procedure as operative bypass. He felt that the operation spared the patient any further interventions during what short time was left. Plastic stents are prone to early occlusion,31 and series using self-expanding metal stents report long-term occlusion rates ranging from 23% to 27%.32-34 His concerns are real, as confirmed by our re-intervention rate of 14%. However, radiological or endoscopic re-intervention does not necessarily equate to less than satisfactory palliation. In Lai et al.'s comparative historical series,35 although the non-operative group required more frequent readmissions to deal with stent occlusion, there was no demonstrable difference
in quality of life between the 2 groups. Most stent occlusions can be dealt with radiologically or endoscopically as we did in 2 of our patients. If follow-up is good and the development of jaundice is recognised early, then appropriate intervention can be elective with minimal inconvenience to the patient. There has never been a double-blind randomised trial comparing stenting with operative bypass, and results are further confounded by the tendency to select patients for stenting on the basis of co-morbidity and advanced malignancy. Neo-adjuvant therapy has been advocated by some authors further complicated.

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of mathematical models have been derived from pooled data to predict poor outcome in patients with malignant hilar obstruction and thus select patients for non-operative palliation. However these scoring systems remain cumbersome and their universal applicability is unclear.

Ultimately local bias, referral patterns and available expertise influence the choice of therapy. We feel that PTC can be performed with minimal morbidity and can provide sustained relief of jaundice. If the event of occlusion salvage is usually possible, either endoscopically or percutaneously. Operative bypass is a major abdominal operation, which carries a definite mortality rate. We have moved away from operative bypass for all but the fittest of patients, or for patients who undergo laparotomy with intention to resect.

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REFERENCES