

ABSTRACT
In pancreas and kidney transplantations, the donor duodenum and pancreas are frequently anastomosed to the jejunum to allow exocrine drainage by creation of a Roux-en-Y jejunal loop. In this situation, those organs are relatively inaccessible using standard endoscopes. We present a case of the use of single-balcon enteroscopy in the treatment of chronic pancreatitis in the donor pancreas.

PANCREAS transplantation (PT) with Roux-en-Y enteric drainage adds difficulty to accessing the periampullary region to locate the duodenal-enteric anastomosis. In some situations, sphincter of Oddi dysfunction may be responsible for pancreatitis. Single-balloon enteroscopy (SBE) can be used in these patients. Herein we have reported a case in which SBE with precut papillotomy was performed on a patient who presented with recurrent idiopathic pancreatitis in the graft after simultaneous pancreas plus kidney transplantation (SPKT), in whom we had performed portoenteric anastomosis drainage by a Roux-en-Y.

CASE REPORT
A 37-year-old white man underwent SPKT with Roux-en-Y portoenteric anastomosis. At 2 years postoperatively, he experienced acute recurrent pancreatitis. Doppler ultrasound showed a normal transplanted kidney. The pancreatic graft revealed a tapered parenchyma with changes in echogenicity. We hypothesized a Roux-en-Y obstruction that was excluded by radiography. SBE was performed via endoscopic retrograde cholangiopancreatography. The enteroscope was passed 1 meter beyond the ligament of Treitz until we visualized the Roux-en-Y latero-lateral enteric anastomosis (Fig 1). The graft papilla of Vater was identified to be bulging corresponding to the donor’s common bile duct, which explained the blockage of pancreatic exocrine drainage. Precut papillotomy was performed achieving good biliary drainage under general anesthesia and required 2 hours. There were no complications and he was discharged after a 2-day postoperative period.

DISCUSSION
One of the exocrine drainage techniques for PT is Roux-en-Y drainage. When this procedure is performed, the possibility to reach the duodenal-enteric anastomosis is remote, treatment of idiopathic pancreatitis cannot be undertaken noninvasively. Our patient presented recurrent pancreatitis with normal imaging examinations (ultrasound, CT, MRI) and did not exhibit other causes of pancreatitis.

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Fig 1. Duodenojunostomy and the viewing of the papilla (B) in the donor duodenum (A).
angio computed tomography, and nuclear magnetic resonance). The cause of pancreatitis was clarified through SBE which enabled an approach to the graft perianampullary region to perform papillotomy without complications. Enteroscopy allowed an adequate approaching to the transplanted pancreatic duodenal loop, enabling efficient treatment of the graft’s biliary and pancreatic pathologies.

REFERENCES