

## Letters to the Editor

### Cholelithiasis during pregnancy successfully resolved with endoscopic retrograde cholangiopancreatography

*Key words: Endoscopic retrograde cholangiopancreatography (ERCP). Pregnancy. Cholelithiasis. Laparoscopy. Surgery.*

Dear Editor,

We read with great interest the editorial by Dr. Lopez-Rosés (1) and the article by Dr. Garcia-Cano et al. (2). We would like to congratulate the authors of both papers, with which we agree in their approach, and to present a new case of cholelithiasis during pregnancy we have had the opportunity to address in our center by endoscopic retrograde cholangiopancreatography (ERCP) and deferred laparoscopic cholecystectomy. We will also make some comments that could complement the therapeutic approach to this problem that we will probably have to face more often in the future.

#### Case report

A 35-years-old pregnant female at 28 weeks of gestation who came to the Obstetrics Emergency Department complaining of colic abdominal pain in the epigastrium radiating to lower back. Obstetric examination was normal, the patient was afebrile and abdominal examination showed tenderness in epigastrium without defense or peritoneal irritation, blood count was normal as well the urine samples. The pain did not respond to regular analgesic treatment, so she was admitted for surveillance. On the fourth day, there was improvement in pain but appeared jaundice,

dark urine, subconjunctival jaundice, and itching erythematous and micropapules skin lesions. Blood samples remained normal, with abnormal liver function tests showing cholestasis characteristic pattern. Abdominal ultrasound (Fig. 1), demonstrated a normal sized liver, gallbladder stones and common bile duct slightly dilated, with a single stone on it distal segment and normal pancreas. With the diagnosis of cholelithiasis and choledocholithiasis and after multidisciplinary meeting and consent of the patient, we decided to practice therapeutic ERCP (Fig. 2) with sedation, after fetal lung maturation and two seconds fluoroscopy. We found a normal papilla that was easily cannulated into a slightly dilated bile duct containing a 1 cm stone in its distal third. Sphincterotomy was performed, complete stone removal with basket and balloon sweeping after washing and stripping without incident, producing an improvement of the patient and a normalization of liver function tests. The birth took place at 35 weeks by cesarean section because of intrauterine growth retardation and breech presentation with a live fetus and uncomplicated. A month later, an uneventful laparoscopic cholecystectomy was performed, with both patient and her son asymptomatic, after five years of monitoring.

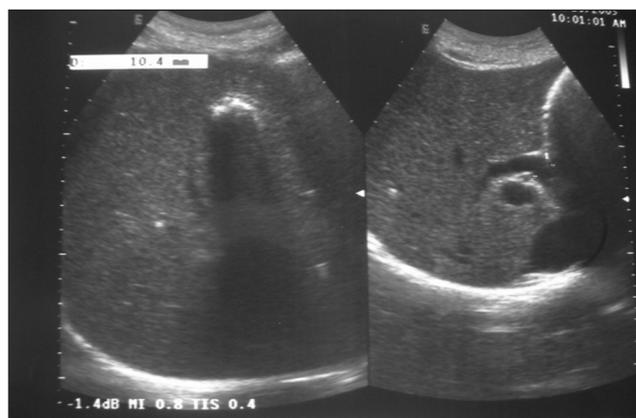


Fig. 1. Abdominal ultrasound showing gallbladder stones and common bile duct dilated, with a single stone impacted on the papilla.

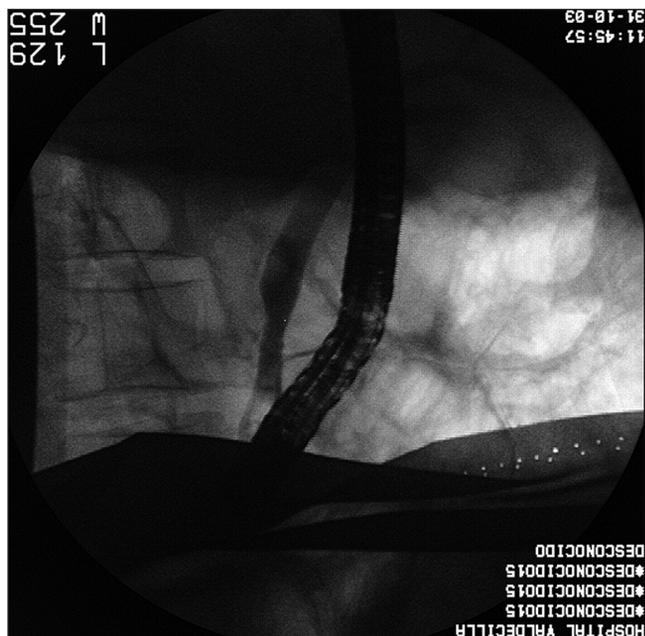


Fig. 2. ERCP showing a common bile duct dilatation with a stone impacted on the papilla.

## Discussion

Pathology of the biliary tract is the second most common cause of no obstetric surgical emergency during pregnancy (3) and its management is controversial, since it may cause maternal or fetus morbidity and mortality constituting a real challenge for professionals involved in its treatment.

There is no doubt about ERCP during pregnancy can be an effective and safe procedure (1,2,4) as is also evident in the case presented, but we must not forget that there are alternatives that can also be safe as is laparoscopic surgery. In the case of pregnancy, represented an absolute contraindication for the same at the beginning of the nineties (5), shortly after it shown as a safe and effective alternative in the case of laparoscopic cholecystectomy, with no maternal or fetus mortality, spontaneous abortions or preterm delivery in the three trimesters of pregnancy (6-8). In the case of cholecystectomy and laparoscopic approach to choledocholithiasis in pregnant women has also been communicated successfully (5,9,10) that in a moment of full expansion and development of laparoscopy should be considered in the future.

We would like to conclude saying that, currently, there is still discussion about the scientific evidence on the best therapeutic option in the management of symptomatic choledocholithiasis in the general population. In pregnancy, where we do not have large and uniform studies yet (1,2), the decision would have to be even more consensual. This decision should be based on the best choice for health and maternal-fetal safety that a multidisciplinary team can offer, depending on the area in which we develop our professional activity, and human and technological resources at our disposal.

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