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Endoscopic Treatment of Cystic Dilation of the Bile Duct Stage III of TODANI, Complicated by Lithiasis.

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We report the case of Mr MA 35 years old with a history of several episodes of self-limiting jaundice during adolescence, never explored, hospitalized for access of cholangitis without cholestasis. In imaging, it had a cystic dilation of the intraduodenal bile duct with a macro lithiasis within it of 03 cm, this which corresponds to Todani type III [Figure 1]. ERCP initially confirmed the diagnosis [Figure 2].

We made an incision in the bile duct cyst [Figure 3], which made it possible to extract the macro lithiasis, being careful not to release it in the hail, to avoid gallstone ileus [Figure 4]. Evolution was simple without complication and the endoscopic control at one year showed a collapse of the cyst without signs of degeneration.

Cystic dilation of the bile duct or choledococele is a rare malformation of the bile ducts, approximately 3000 cases have been described worldwide. There is an east-west gradient: 1 case/ 200,000 H in the countries Westerners and 1/15,000 M in Japan, and the female predominance is clear, with a sex ratio of 4F/1M [1,2].

Usually, this malformation is diagnosed during the neonatal period, or during childhood, following cholestatic jaundice; 50 to 75% of cases are discovered before the age of 15. Rarely, this form is diagnosed in adulthood when complications appear. TODANI Type III represents between 0 and 2% of cases of cystic dilatation of the bile duct [3]. The diagnosis is made by imaging, in particular BILI MRI. Complications are related to chronic cholestasis which can bethe origin of cholangitis, intra-cystic gallstones, hepatic abscess and acute pancreatitis [4]. The risk of cholangiocarcinoma is estimated at 1.6% of cases [5]. The choice of treatment depends on the size of the choledococele. It is usually endoscopic (incision of the cyst ± extraction of stones); but if the size exceeds 3 cm, surgical excision is necessary. This has not demonstrated its superiority in terms of cancer prevention. Surgical treatment by duodenotomy is reserved for cases with obstruction duodenal [6]. After endoscopic treatment, long-term follow-up with endoscopic monitoring and echo-endoscopy is essential because of the risk of periampullary cancer. [6].

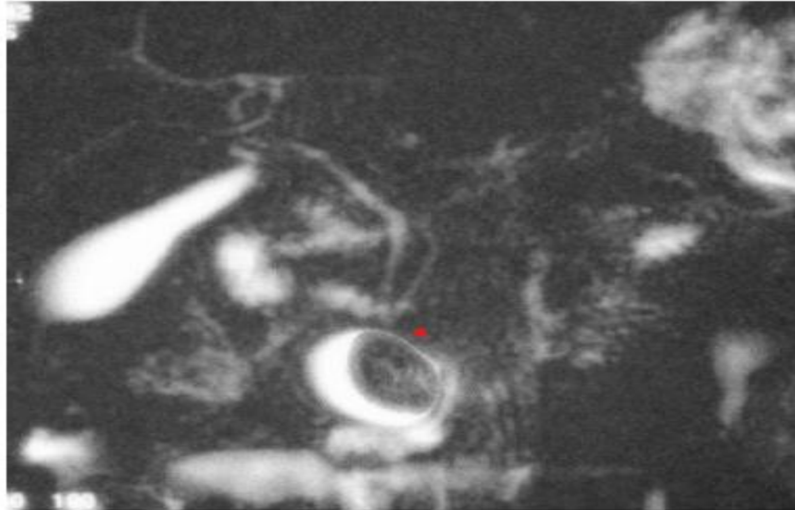

Figure 1. Bili MRI; Cystic dilatation of the bile duct type III of TODANI with Macrolithiasis.

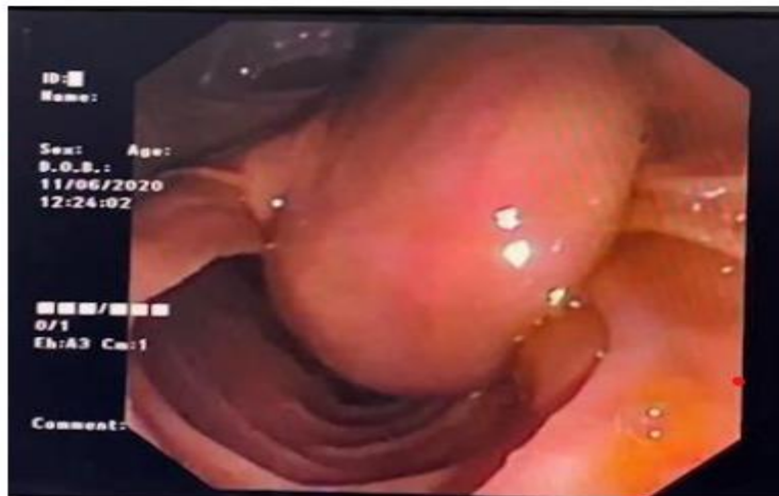

Figure 2. Cystic dilatation of the common bile duct seen in lateroscopy.

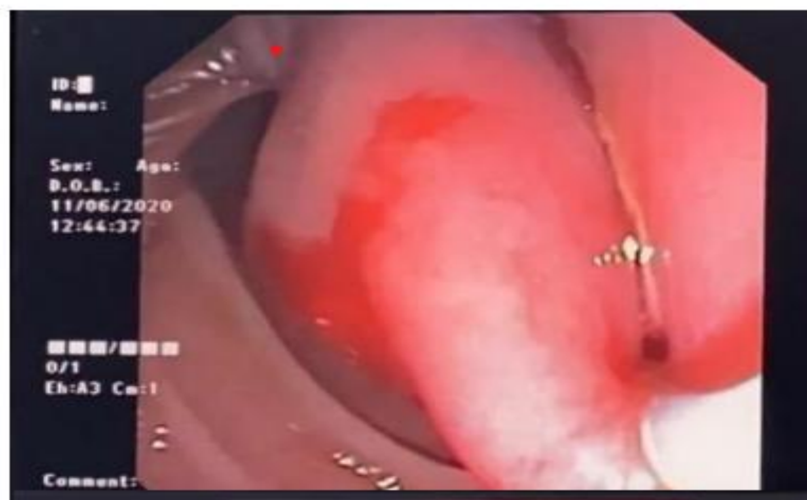

Figure 3. Common bile duct cyst incision by ERCP.

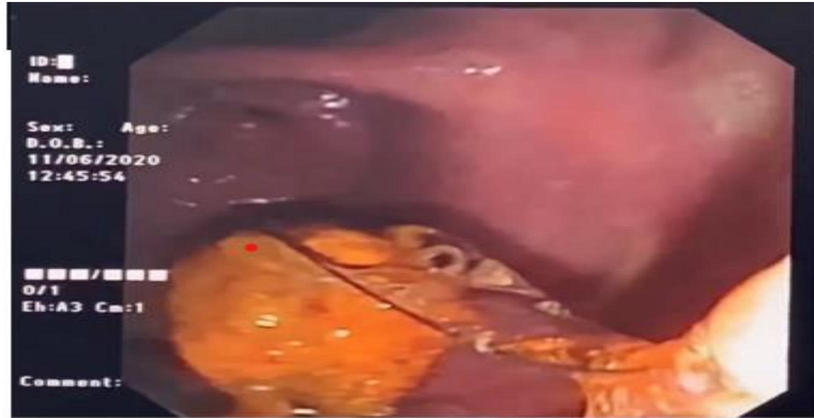

Figure 4. Extraction of the Macrolithiasis from The Cyst.

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