



20th International Symposium on Pancreatic & Biliary Endoscopy

With Live ERCP Demonstrations from Cedars-Sinai Medical Center
and Santiago, Chile

January 25 - 27, 2013

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COURSE DIRECTORS

Simon K. Lo, MD
David Carr-Locke, MB, BChir
Paulo Sakai, MD

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ACTIVITY INFORMATION

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COURSE DESCRIPTION

The Cedars-Sinai 20th Annual International Symposium on Pancreatic and Biliary Endoscopy teaching conference will be held in cooperation with three major endoscopy centers in Los Angeles, New York and São Paulo. Balanced viewpoints, special techniques and practical clinical approaches will be presented throughout the program by renowned international faculty who bring unique knowledge, skills and excitement from North and South America.

Collaborating with Claudio Navarrete, MD at the Clinica Alemana de Santiago, the program will feature transmission of live procedures from Santiago, Chile. Together with multiple transmissions from Cedars-Sinai Medical Center, a total of 11 hours of ERCP procedure demonstrations will be offered so that participants can witness the different skills and equipment used to treat various pancreatic and biliary conditions.

This year's special features include:

- Eleven hours of ERCP procedure demonstrations telecast live from Cedars-Sinai Medical Center and Santiago, Chile
- Twenty clinically coherent and carefully chosen didactic topics, including current literature review
- Ample time for questions and discussion throughout the program
- Case conference to apply technical skills to challenging clinical scenarios
- Concurrent GI Fellows' Program
- Bonus Session for GI Fellows and Nurses

TARGET AUDIENCE

This educational activity will provide an intensive and comprehensive review of pancreatic and biliary endoscopy for gastroenterologists, gastroenterology fellows and gastroenterology nurses in attendance.

EDUCATIONAL OBJECTIVES

- Shorten fluoroscopy time during ERCP and improve reporting of the procedures
- Perform cholangioscopy safely and effectively without adding unnecessary procedure cost
- Apply the alternative treatment options to ERCP including, transluminal direct biliary drainage, internal biliary rendezvous, pancreatic ductal access, pancreatic fluid
- Recognize the roles of endoscopic ultrasound, ERCP, MRCP and pancreatoscopy in diagnosing Intraductal Papillary Mucinous Neoplasm (IPMN)

ACCREDITATION STATEMENT

Cedars-Sinai Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.



CREDIT DESIGNATION STATEMENT

Cedars-Sinai Medical Center designates this live activity for a maximum of 21.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

RADIOLOGY AND FLUOROSCOPY

11.0 credits of the course (specific to ERCP demonstrations) may meet requirements in the State of California toward renewal of the radiology and fluoroscopy supervisor license.

CONTINUING NURSING EDUCATION

The California State Board of Registered Nursing accepts courses approved by the ACCME for category 1 credit as meeting the continuing education requirements for license renewal.

INTERVENTIONAL FELLOWSHIP

Gastroenterologists interested in applying for an Interventional Endoscopy Fellowship are invited to contact Simon Lo, MD. Send an e-mail with your contact information and "interventional endoscopy fellowship" in the subject line to simon.lo@cshs.org. You may also want to attend the optional interventional fellowship lecture on Saturday (see program agenda).

POLICY ON DISCLOSURE

It is the policy of Cedars-Sinai Medical Center to ensure balance, independence, objectivity, and scientific rigor in all of its educational activities. Cedars-Sinai Medical Center assesses conflict of interest with its faculty, planners and managers of CME activities. Conflicts of interest that are identified are resolved by reviewing that presenter's content for fair balance and absence of bias, scientific objectivity of studies utilized in this activity, and patient care recommendations.

While Cedars-Sinai Medical Center endeavors to review faculty content, it remains the obligation of each physician or other healthcare practitioner to determine the applicability or relevance of the information provided from this course in his or her own practice.

ACKNOWLEDGMENT OF COMMERCIAL SUPPORT

Cedars-Sinai Medical Center gratefully acknowledges the independent educational grants and in-kind equipment in support of this activity from **Cook Medical** and **Olympus Corporation of the Americas**. Additional commercial support is pending and will be disclosed at the symposium.

AGENDA

FRIDAY, JANUARY 25, 2013

7:00 AM	Registration / Continental Breakfast	
8:00	Welcome and Opening Remarks	<i>Andrew Ippoliti, MD and David Carr-Locke, MB, BChir</i>

BRINGING US UP TO DATE

8:05	2012 Pancreatic & Biliary Endoscopy Literature Review	<i>David Carr-Locke, MB, BChir</i>
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STONES

Moderators: Paulo Sakai, MD and Simon Lo, MD (HMA); Charles Menz, MD (HM4-6)

8:30	Extraction of Difficult Stones: Large Sphincterotomy, Balloon Dilation, Mechanical Lithotripsy or EHL?	<i>Gregory B. Haber, MD</i>
8:50	What Are the Concerns and Precautions for Balloon Sphincteroplasty?	<i>Paulo Sakai, MD</i>
9:10	The Role of ERCP in Pancreaticolithiasis	<i>D. Nageshwar Reddy, MD</i>
9:30	Question & Answer Session	<i>Panel</i>
9:50	Break	

TRANSLUMINAL PB PROCEDURES: INDICATIONS, TECHNIQUES & SAFETY

Moderators: Robert Hawes, MD and D. Nageshwar Reddy, MD (HMA); Stanley Dea, MD (HM4-6)

10:10	Internal Biliary Rendezvous	<i>Laith H. Jamil, MD</i>
10:30	Transluminal Direct Biliary Drainage	<i>Kapil Gupta, MD, MPH</i>
10:50	Pancreatic Ductal Access and Stenting	<i>Robert Hawes, MD</i>
11:10	Pancreatic Fluid and Pseudocyst Management: Beyond Basic Drainage	<i>Kenneth F. Binmoeller, MD</i>
11:30	A Surgeon's View Toward Transluminal GI Procedures	<i>Nicholas Nissen, MD</i>
11:50	Question & Answer Session	<i>Panel</i>
12:10	Lunch	

LUNCH LECTURES: THE PRACTICE OF ERCP

Moderators: Neel Mann, MD (HMA); Stanley Dea, MD (HM4-6)

12:40	Legal Considerations	<i>David Carr-Locke, MB, BChir</i>
1:00	Quality Assurance	<i>Firas H. Al-Kawas, MD</i>

LIVE PROCEDURE DEMONSTRATIONS

1:20	Live ERCP and EUS – Session I	<i>Moderators: Viktor Eysselein, MD and Jacques Van Dam, MD (HMA); Theodore Stein, MD (HM4-6)</i>
2:40	Live ERCP and EUS – Session II	<i>Moderators: John Petrini, MD and Jacques Van Dam, MD (HMA); Theodore Stein, MD (HM4-6)</i>
4:00	Live ERCP and EUS – Session III	<i>Moderators: Firas Al-Kawas, MD and Charles Menz, MD (HMA); Theodore Stein, MD (HM4-6)</i>
5:30 PM	Adjourn	

SATURDAY, JANUARY 26, 2013

7:00 AM	Continental Breakfast	
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LIVE PROCEDURE DEMONSTRATIONS

Moderators: David Carr-Locke, MD; Paulo Sakai, MD (HMA); Jerome Cohen, MD (HM4-6)

8:00	Live ERCP & EUS – Session IV (Transmitted from Santiago, Chile)	<i>Claudio S. Navarrete, MD</i>
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CHOLANGIOSCOPY

Moderators: John Petrini, MD and Jacques Van Dam, MD (HMA); Peter Sender, MD (HM4-6)

9:15	Is There a Role for Percutaneous Cholangioscopy: How Is It Done?	<i>Jong H. Moon, MD, PhD</i>
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LIVE PROCEDURE DEMONSTRATIONS

9:30	Live ERCP & EUS – Session V	<i>Moderators: John Petrini, MD and Jacques Van Dam, MD (HMA); Peter Sender, MD (HM4-6)</i>
10:00	Break (live demonstrations will continue during break)	
10:45	Live ERCP & EUS – Session VI	<i>Moderators: Kenneth Binmoeller, MD and Viktor Eysselein, MD (HMA); Theodore Stein, MD (HM4-6)</i>
12:00 PM	Lunch	
1:00	Live ERCP Session – VII	<i>Moderators: Binesh Batra, MD (HMA)</i>

CHOLANGIOSCOPY

2:30	Performing Babyscope for Diagnosis and Treatment of Cholangiocarcinoma	<i>D. Nageshwar Reddy, MD</i>
2:45	Per-oral Choledochoscopy: The Technique, Pro & Con	<i>Jong H. Moon, MD, PhD</i>
3:00	Break	

LIVE PROCEDURE DEMONSTRATIONS

3:20	Live ERCP & EUS – Session VIII	<i>Moderators: Firas Al-Kawas, MD and Paulo Sakai, MD</i>
5:00 PM	Adjourn	

CONCURRENT GI FELLOWS PROGRAM* – 1:00 PM TO 5:00 PM

OPTIONAL BONUS SESSION FOR FELLOWS, NURSES AND TECHNICIANS* – 5:15 PM TO 7:00 PM

Location: Harvey Morse Rooms 4-6. *No CME credit is provided for these sessions.

CONCURRENT GI FELLOWS' PROGRAM (NURSES AND PRACTICING GASTROENTEROLOGISTS WELCOME!)

Moderators: Stanley Dea, MD and Charles Menz, MD

THE BASICS OF ERCP

1:00 PM	Opening Remarks	<i>Laith Jamil, MD</i>
1:10	Pancreaticobiliary Anatomy: Normal and Anomalies	<i>Stanley Dea, MD</i>
1:35	Cannulation: Instruments and Techniques	<i>Kapil Gupta, MD</i>
1:55	Sphincterotomy: Instruments and Techniques	<i>Firas H. Al-Kawas, MD</i>
2:15	Stone Extraction	<i>James Farrell, MD</i>
2:30	Management of Migrated Biliary Stents	<i>Robert Hawes, MD</i>
2:45	Break	

CAREER PLANNING FOR INTERVENTIONAL ENDOSCOPY

Moderators: Stanley Dea, MD and Charles Menz, MD

3:00	Considerations and Decisions in Choosing a Third Year Training Program	<i>Vijay Jayaraman, MD</i>
3:15	Training and Research Possibilities for Interventional Fellows	<i>John Petrini, MD</i>
3:25	Career Opportunities for Interventional Fellows: Private or Managed Care Practice	<i>Binesh Batra, MD</i>
3:35	Life of an Interventional Fellow	<i>Gebran Abboud, MD</i>
3:45	Cutting Umbilical Cord: Life after Interventional Fellowship	<i>Christopher Hammerle, MD</i>
3:55	Career Opportunities for Interventional Fellows: Academia	<i>Jacques Van Dam, MD</i>
4:10	Round-table Discussion: An Open Forum	<i>Panel</i>
4:45	Interventional Fellowship at Cedars-Sinai Medical Center	<i>Simon Lo, MD</i>
5:00 PM	Fellow Program Adjourns	

(FELLOWS ARE ENCOURAGED TO STAY FOR OPTIONAL BONUS SESSION AND DINNER – SEE BELOW)

BONUS SESSION FOR FELLOWS, NURSES AND TECHNICIANS

Moderators: Yvonne Min, RN; Rose Chang, RN; Loretta So, RN

5:15	What Do the Experts Do To Overcome Difficult Cannulations?	<i>Paulo Sakai, MD</i>
5:35	Why Do I Often Alter My ERCP Accessories?	<i>Simon Lo, MD</i>
6:05	Quality Indicators for ERCP	<i>Loretta So, RN and Cynthia Edgelow, RN</i>
6:25	Discussion	<i>Panel</i>
6:45	Adjourn	
7:00 PM	Off-Site Dinner	

(LIMITED TO FELLOWS AND NURSES ATTENDING BONUS SESSION)

SUNDAY, JANUARY 27, 2013

7:00 AM Continental Breakfast

CONCURRENT PATIENT MANAGEMENT & HANDS-ON PROCEDURE WORKSHOPS

7:30 to 10:00 AM	FELLOWS HANDS-ON WORKSHOP (HM4-6) <i>Instructors: Firas H. Al-Kawas, MD; Kenneth Binmoeller, MD; Stanley Dea, MD; Laith Jamil, MD; Charles Menz, MD; Jong Moon, MD; John Petrini, MD; Peter Sender, MD</i> <i>Coordinators: Kapil Gupta, MD; Paulo Sakai, MD; Rose Chang, RN; Yvonne Min, RN; Loretta So, RN; Helena Spivak, RN</i>	
7:30 to 10:00 AM	NURSES HANDS-ON WORKSHOP (HM1-3) <i>Coordinators: Cynthia Edgelow, RN; Christopher Hammerle, MD; Vijay Jayaraman, MD</i>	
8:00 to 10:00 AM	PATIENT MANAGEMENT (HMA) Pancreaticobiliary Case Discussions* <i>Moderators: Binesh Batra, MD and Jerome Cohen, MD</i> <i>Panel: David Carr-Locke, MB, BChir; Steven Colquhoun, MD; Gregory Haber, MD; Robert Hawes, MD; Nicholas Nissen, MD; D. Nageshwar Reddy, MD;</i> *AUDIENCE IS ENCOURAGED TO BRING CASES FOR DISCUSSION (SEE REGISTRATION FORM)	
10:00	Break	

IPMN: WHAT HAVE WE LEARNED ABOUT THIS CONDITION?

Moderator: Jacques Van Dam, MD

10:20	EUS Diagnosis	<i>Robert Hawes, MD</i>
10:40	MRCP, ERCP and Pancreatoscopic Features	<i>Gregory Haber, MD</i>
11:00	Surgical Treatment Options	<i>Nicholas Nissen, MD</i>
11:20	Questions & Answers	<i>Panel</i>

LEARNING FROM EXPERIENCE

Moderator: Kenneth Binmoeller, MD

11:40	My Worst Nightmare 1	<i>David Carr-Locke, MB, BChir</i>
11:55	My Worst Nightmare 2	<i>Paulo Sakai, MD</i>
12:10	Symposium Summary	<i>Panel</i>
12:50 PM	Adjourn	

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PROGRAM HIGHLIGHTS

- Live ERCP & EUS procedures
- Literature review, clinical presentations
- Concurrent GI Fellows' Program
- Bonus Session for GI Fellows and Nurses
- Pancreaticobiliary Case Discussions

Effect of Biliary Stenting Combined With Ursodeoxycholic Acid and Terpene Treatment on Retained Common Bile Duct Stones in Elderly Patients: A Multicenter Study

Jimin Han, MD, PhD¹, Jong Ho Moon, MD, PhD², Hyun Cheol Koo, MD², Jee Heon Kang, MD², Joon Hyuck Choi, MD, PhD¹, Seok Jeong, MD, PhD³, Don Haeng Lee, MD, PhD³, Moon Sung Lee, MD, PhD² and Ho Gak Kim, MD, PhD¹

- OBJECTIVES:** For frail, elderly patients with large impacted common bile duct (CBD) stones, long-term treatment with biliary stenting provides palliation. Biliary stenting with choleric agents such as ursodeoxycholic acid (UDCA) and terpene preparations may promote CBD stone size reduction. We studied the effectiveness of biliary stenting combined with UDCA and a terpene preparation as a medical treatment for difficult-to-remove CBD stones in patients older than 65 years in this multicenter, prospective study.
- METHODS:** A total of 28 elderly patients with CBD stones refractory to conventional endoscopic removal, including mechanical lithotripsy, underwent endoscopic placement of a straight 10-F plastic biliary stent. Each patient was administered 600 mg of UDCA and 300 mg of a terpene preparation daily for a mean of 6 months. After 6 months of medication following the initial endoscopic retrograde cholangiopancreatography (ERCP), a second ERCP was performed and endoscopic stone removal was again attempted. Differences in stone size and CBD diameter before and after biliary stenting and medication were compared. The complete stone removal rate after treatment was obtained.
- RESULTS:** The mean size (transverse × longitudinal diameter) of the CBD stones was initially 21.6×29.5 mm, and it decreased significantly to 12.2×20.1 mm at the second ERCP ($P<0.01$). The mean CBD diameter measured initially at the cystic duct insertion level was 23.2 mm, and it decreased significantly to 19.5 mm at the second ERCP ($P<0.01$). After biliary stenting with medication, endoscopic stone removal was successful in 26 of 28 patients (92.8%), with a mean of 1.7 subsequent ERCP sessions.
- CONCLUSIONS:** Endoscopic biliary stenting with a period of combined UDCA and terpene preparation administration seems to be a safe and effective method for retained CBD stones in elderly patients. A prospective study with randomization and a control group is required to confirm these results.

Am J Gastroenterol advance online publication, 30 June 2009; doi:10.1038/ajg.2009.303

INTRODUCTION

More than 80–90% of common bile duct (CBD) stones can be removed completely with endoscopic sphincterotomy followed by stone extraction (1). However, additional methods

are necessary for the removal of the remaining 10–20% of CBD stones that are difficult to extract (1–3). Of the various modalities, biliary stenting has an important role in the conservative management of CBD stones refractory to conventional

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endoscopic removal in elderly patients. The major aim of biliary stenting is the prevention of stone impaction at the ampulla and cholangitis, which is a life-threatening complication. However, whenever possible, a complete removal of difficult-to-extract CBD stones should be the final aim, even in elderly patients, because of complications associated with long-term biliary stenting.

After long-term treatment with biliary stenting for large CBD stones, stone fragmentation that enabled complete stone removal has been observed with variable, unsatisfactory success rates (2,4). Ursodeoxycholic acid (UDCA) is a hydrophilic dihydroxy bile acid that can dissolve gallstones (5,6). Combining oral UDCA with biliary stenting for the treatment of CBD stones that are difficult to remove can increase the rates of stone fragmentation and size reduction (5). A terpene preparation has been shown to enhance the solubility of cholesterol and also that of calcium carbonate and calcium phosphate, making it a potent choleric agent (7,8). The addition of both a terpene preparation and UDCA to biliary stenting may have a synergistic effect on facilitating the dissolution of bile duct stones (8–10). Therefore, we conducted a multicenter, prospective feasibility study to evaluate the effectiveness of biliary stenting combined with UDCA and a terpene preparation for difficult-to-remove CBD stones.

METHODS

Patients

From October 2005 to September 2008, 28 elderly patients over the age of 65 years and with difficult-to-remove CBD stones were enrolled. The patients presented with one or more of the following: biliary pain, jaundice, and fever. A difficult CBD stone was defined as a large and impacted CBD stone that was unable to be endoscopically removed, either by major endoscopic sphincterotomy or by mechanical lithotripsy. Extracorporeal or intracorporeal lithotripsy was not used for stone removal in this study. Exclusion criteria included the patient's or caregiver's refusal of treatment, a life expectancy of <6 months, and a history of side effects to UDCA and/or to a terpene preparation. The institutional review board at each participating hospital approved this study. Written informed consent was obtained from all of the enrolled patients.

Procedures

Three endoscopic retrograde cholangiopancreatography (ERCP) endoscopists (J.H.M., D.H.L., and H.G.K.) with experience of more than 600 sessions of ERCP per year over the last 10 years were involved in this study, and each endoscopist interpreted the cholangiograms independently and consecutively. All the investigators participating in the study recorded the findings independently on a standardized data form. Cholangiograms were obtained after a full contrast injection, with the patient in the prone position and the duodenoscope in the shortened position. The initial CBD diameter and CBD stone size were measured from the cholangiogram obtained

during the initial ERCP by the same endoscopist who performed the ERCP. The CBD diameter was arbitrarily defined as the width of the CBD at the cystic duct insertion level, and the CBD stone size was defined as the maximum transverse diameter times the maximum longitudinal diameter. The CBD diameter and stone size were corrected for radiograph magnification by multiplying the ratio of the actual and measured diameters of the duodenoscope on the cholangiogram. The number of CBD stones was also recorded. After the attempted endoscopic removal failed, a single straight 10-F plastic biliary stent was placed, with the proximal end above the top of the difficult CBD stone. After the initial ERCP, each patient was administered daily medication consisting of 600 mg of UDCA (Ursa; Daewoong, Seoul, Korea) and 300 mg of a terpene preparation (Rowachol; Rowa Pharma, Cork, Ireland). The medications were continued for a mean of 6 months. The patients underwent regular follow-up every 4 weeks at an outpatient clinic, during which blood chemistry, simple abdominal X-rays, and compliance with the medication were checked.

After 6 months of medication, a second ERCP was performed by the same endoscopist who had performed the first ERCP. CBD diameter and CBD stone size and number were measured again using the same method and definitions, for comparison with the values at the initial ERCP. Endoscopic stone removal was attempted again using conventional endoscopic procedures, including mechanical lithotripsy.

Statistical analysis

The results are expressed as means±s.d. To compare differences in variables between the initial and second ERCP, the Wilcoxon signed-rank test was used. SPSS for Windows ver. 11 (SPSS, Chicago, IL) was used to analyze the data, and $P < 0.01$ was considered statistically significant.

RESULTS

Of the 28 patients, 10 (35.7%) were men and 18 (64.3%) were women. The mean patient age was 74.5±6.2 (range: 65–88) years, and the mean number of CBD stones was 2.5±1.8 (range: 1–7).

Both the transverse and longitudinal diameters of the CBD stones decreased significantly after biliary stent placement and medication with UDCA and the terpene preparation (**Table 1**). In addition, the CBD diameter decreased significantly (**Table 1**). Stone size was reduced in 27 patients, remained unchanged in 1, and increased in none.

On follow-up ERCP, a spontaneous evacuation of the CBD stones was observed in one patient. Complete stone removal was achieved using only the basket and retrieval balloon catheter, without other additional procedures, in 16 (57.1%) patients (**Figure 1**). Ten patients (35.7%) required mechanical lithotripsy for complete stone removal. Thus, complete stone removal was achieved in 26 of 28 patients (92.8%) after biliary stenting with medication. The two patients with incomplete stone removal underwent long-term stent placement. The number of additional ERCP sessions required for complete stone removal was 1.7±0.8 (range: 1–3).

No immediate or late complications related to biliary stent placement or endoscopic stone removal were observed. Of the 28 patients enrolled in the study, there was no case of spontaneous dislocation of the biliary stent. No significant adverse side effects from the administration of either UDCA or the terpene preparation occurred, except for transient mild diarrhea in six patients.

DISCUSSION

This study evaluated the effectiveness of biliary stenting combined with UDCA and a terpene preparation administered as a medical treatment for retained CBD stones. Complete stone removal was achieved in ~90% of the 28 elderly patients with difficult-to-extract CBD stones. Moreover, no significant complications related to biliary stent placement or medication occurred.

Table 1. Changes in CBD stone size and CBD diameter after biliary stent placement and medication with ursodeoxycholic acid and a terpene preparation in elderly patients

Parameter	Initial ERCP	Follow-up ERCP	P value
<i>CBD stone size (mm)</i>			
Transverse diameter	21.6±6.2	12.2±4.9	<0.01
Longitudinal diameter	29.5±14.3	20.1±1.2	<0.01
CBD diameter (mm)	23.2±6.1	19.5±3.8	<0.01

CBD, common bile duct; ERCP, endoscopic retrograde cholangiopancreatography.

Although more than 80–90% of CBD stones can be removed endoscopically, the remaining 10–20% are refractory to endoscopic removal, despite advanced lithotripsy methods (1). In elderly, frail patients who are poor candidates for surgery, biliary stenting has been used as a temporary, bridging measure to prevent stone impaction and acute cholangitis. Although biliary stenting provides immediate and successful drainage in 96% of cases, with a low early complication rate of 11%, the rate of long-term complications reached 40% in a group of 52 patients (11). Biliary stenting alone can reduce the size of CBD stones, but its effect on stone size is inconsistent, and the biliary stent must be exchanged in the case of occlusion or migration (2,4,10).

Both UDCA and terpene preparations have been used for their ability to dissolve gallstones (5,7). They have different mechanisms of action. UDCA, a hydrophilic dihydroxy bile acid (3 α ,7 β -dihydroxy-5 β -cholanoic acid), reduces the lithogenicity of bile by decreasing the biliary lipid output of cholesterol (6). In contrast, the terpene preparation is a well-tolerated oil preparation containing six cyclic monoterpenes; it inhibits hepatic hydroxymethyl glutaryl-coenzyme A reductase, alters biliary cholesterol saturation, can dissolve gallstones, and is more effective at low rather than at high dosages (12,13). It enhances the solubility of cholesterol as well as that of both calcium carbonate and calcium phosphate, making it a potent choleric agent (7). In normal healthy volunteers, a terpene preparation increased biliary cholesterol and phospholipid secretion, as well as bile acid secretion, but did not alter the composition of biliary lipids or the lithogenicity of bile. A terpene preparation alone has only weak litholytic properties, at least in normal volunteers. However, combining a terpene preparation with

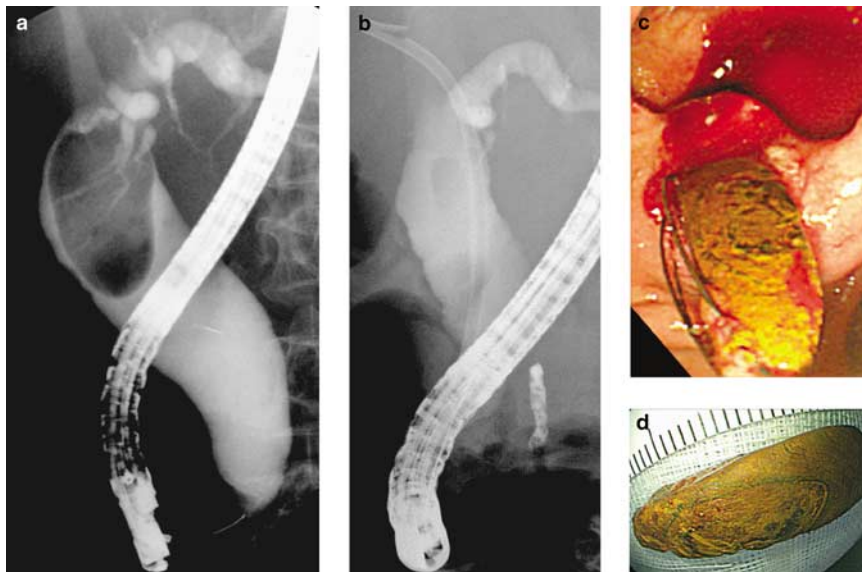


Figure 1. Representation of a cholangiogram of a 74-year-old woman with a large common bile duct (CBD) stone who underwent successful endoscopic stone removal after biliary stenting and 6 months of ursodeoxycholic acid (UDCA) and terpene preparation administration. (a) The cholangiogram obtained at the initial endoscopic retrograde cholangiopancreatography shows a single, large, filling defect within the CBD. (b) After inserting a 10-F plastic biliary stent and treatment with UDCA and a terpene preparation for 6 months, the cholangiogram showed a significant decrease in the size of the stone. (c and d) Subsequently, the stone was removed successfully using only a Dormia basket.

UDCA may have several advantages, including the accelerated dissolution of gallstones (3,9), more effective reduction in bile lithogenicity (7), and a lower required dose of UDCA.

In a recent randomized, blinded trial on the combination of plastic biliary stents and oral UDCA of 750 mg or placebo for 6 months, there was no significant difference in CBD stone clearance (76.9 vs. 75%), stone size reduction (0.40 ± 0.04 vs. 0.37 ± 0.04 cm), or number of patients with stone fragmentation (7 vs. 5) between the two groups (5). Few studies have examined the medical treatment of gallstones with a terpene preparation alone or in combination with bile acid derivatives (3,8). Complete or partial dissolution of gallstones was seen in 41% of cases after 6 months. In contrast, dissolution occurred in 15% of a terpene preparation-only group but in 0% of a chenodeoxycholic acid-only group (3). In patients with CBD stones, daily treatment with three capsules of a terpene preparation resulted in complete or partial stone dissolution in 46% of cases after 6 months and in 67% after 1 year (9). No major side effects related to the terpene preparation occurred. Therefore, the addition of UDCA and a terpene preparation to biliary stenting may have a synergistic effect on the fragmentation of retained CBD stones, thereby facilitating endoscopic removal at a later date.

As expected, the diameters of both the CBD and CBD stones decreased significantly after treatment with biliary stenting and the combination of UDCA and a terpene preparation in our study. Complete endoscopic stone removal was achieved in 92.8% of the patients, which is a higher rate than that reported in previous studies (4,5). Biliary stenting combined with UDCA and a terpene preparation was not only effective in the management of retained CBD stones but also safe. No serious complications related to either biliary stenting or treatment with UDCA and a terpene preparation were observed.

The limitations of this study are the small number of patients enrolled and the lack of a control group. Given that the success rate of endoscopic CBD stone removal exceeds 80–90% (1), enrolling a large number of patients with retained CBD stones was difficult, and the small number of patients with retained CBD stones made the recruitment of a control group unfeasible. On account of these limitations, it is difficult to be absolutely certain that the combination therapy was solely responsible for the benefits seen.

In conclusion, biliary stenting combined with the administration of UDCA and a terpene preparation seems to be a safe and effective method for treating difficult CBD stones in elderly patients. To validate these results, a randomized prospective study comparing the results of biliary stenting only, biliary stenting combined with UDCA, and a terpene preparation with respect to a control group is required.

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CONFLICT OF INTEREST

Guarantor of the article: Jong Ho Moon, MD, PhD.

Specific author contributions: Study design, data analysis, and script preparation: Jong Ho Moon and Jimin Han;

endoscopic diagnosis and treatment: Jong Ho Moon, Don Haeng Lee, and Ho Gak Kim; data collection: Hyun Cheol Koo, Jee Heon Kang, Joon Hyuck Choi, and Seok Jeong; reviewers of the paper: Don Haeng Lee, Moon Sung Lee, and Ho Gak Kim. All authors have read and approved the submitted version of the paper.

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Study highlights

WHAT IS CURRENT KNOWLEDGE

- ✓ Elaborate additional methods are necessary for the 10–20% of common bile duct (CBD) stones that are difficult to extract on endoscopic retrograde cholangiopancreatography. Biliary stenting has an important role in the conservative management of CBD stones in elderly patients, but it is not a definite treatment.

WHAT IS NEW HERE

- ✓ Biliary stenting combined with a period of treatment with ursodeoxycholic acid and a terpene preparation decreased the size of CBD stones, allowing successful endoscopic stone removal in 92.8% of elderly patients with difficult, retained CBD stones.

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