CEDARS-SINAI MEDICAL CENTER

Operative & Procedure Notes

Procedures signed by Gaddam, Srinivas, MD at 5/17/2018 9:52 PM

Author: Gaddam, Srinivas, MD | Service: Gastroenterology | Author Type: Physician
Filed: 5/17/2018 9:52 PM | Date of Service: 5/16/2018 5:32 AM | Status: Signed
Editor: Gaddam, Srinivas, MD (Physician)

Procedure Orders:
1. PANCREATICOBILIARY PROCEDURE [289279784] ordered by Gaddam, Srinivas, MD at 05/15/18 2304

CEDARS-SINAI MEDICAL CENTER

Center for Digestive Diseases
Pancreaticobiliary and Interventional Gastroenterology

PATIENT: [redacted] NATHAN
MED REC: 000196861
DICTATOR: SRINIVAS GADDAM, MD

PROCEDURE NOTE

DATE OF OPERATION: 05/15/2018

PROCEDURE PERFORMED:
1. Double-balloon-assisted endoscopic retrograde cholangiopancreatography.
2. Status post nasojejunal tube placement.

ENDOSCOPIST: Srinivas Gaddam, MD

REFERRING PHYSICIAN: Benjamin Basseri, MD

ASSISTANT ENDOSCOPIST: None.

ATTESTATION STATEMENT: I personally performed the entire procedure.

INDICATION(S): Jaundice, elevated white count, and recent history of pancreatitis.

BACKGROUND: [redacted] has had ampullary adenocarcinoma, status post Whipple at Saint John's in November 2017. At the time, chemoradiation was deferred, and the patient has had multiple UTIs in the past, for which he has an indwelling Foley catheter, and his urine did not look worse; however, he now presents with failure to thrive, weight loss, persistent white count, and jaundice.

Operative & Procedure Notes (continued)

Procedures signed by Gaddam, Srinivas, MD at 5/17/2018 9:52 PM (continued)

The patient was hospitalized at Saint John's Hospital 1-2 weeks ago for malaise/fatigue and was told he had acute pancreatitis, and his PICC line was discontinued subsequently. His clinical course has been complicated by PICC line infections, and he is currently on antibiotics. MRI/MRCP did not show any significant ductal dilation; however, there was suspicion for possible obstructed surgical stent and, therefore, ERCP was being pursued.

I discussed at length with the patient regarding risk of infection, bleeding, perforation, and small risk of pancreatitis. He understands risks/benefits and has consented to the procedure. I had a prolonged discussion about feeding tube, possible PEG tube, and at the end, we decided that we would place an NJ tube, and the patient and his daughter would discuss further to come to a conclusion about the need for a PEG tube.

PROCEDURE DETAIL AND TECHNIQUE: I discussed with the patient regarding risks of infection, bleeding, perforation, and pancreatitis. The patient's daughter understands the risks/benefits and has consented to proceed.

After written informed consent was signed, the patient was taken to procedure room #7. He was laid in a prone position. The upper endoscope was then advanced through the mouth, into the gastroduodenostomy, what appeared to be appeared to be a pyloric-sparing duodenojejunostomy. Here, the afferent limb was easily cannulated. The scope was then advanced into the afferent limb as far as possible. The scope was then switched to a pediatric colonoscope, and that could not traverse the sharp, acute angulation at the undersurface of the liver. On fluoroscopic image, this was located at the right inferior surface of the liver towards the lateral abdominal wall. Multiple position changes and abdominal pressure were applied without any success. At this point, the scope was then switched for a double-balloon scope, and this was then advanced beyond the area with significant difficulty. It was noted that the patient's small bowel, stomach, and esophagus are friable and bleed easily to touch, and on withdrawal of the pediatric colonoscope, small submucosal hematomas were noted in the esophagus.

The double-balloon scope was then advanced to the hepaticojejunostomy. The double-balloon scope on x-ray had a pretzel shape when advanced into that location. This is highly suspicious for an afferent loop syndrome. The contrast was injected into the biliary tree, and the

Operative & Procedure Notes (continued)

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hepaticojejunostomy appeared to be widely patent. The entire evaluated biliary tree and cholangiogram were normal. At this point in time, the scope was then advanced with significant difficulty to the pancreaticojejunostomy. The pancreatic orifice could not be clearly visualized; however, that area was localized. Further manipulations with wire and balloon were not performed given that the patient had a recent episode of pancreatitis. The scope was then withdrawn, and using an upper scope and over a wire, the nasojejunal tube was then placed into the jejunum. This was then injected with contrast to confirm placement. The scope was then withdrawn. The procedure was then terminated.

PROCEDURE FINDINGS: As above.

IMPRESSION(S):
1. Severe angulation in the afferent limb about 10-15 cm distal to the hepaticojejunostomy; this is suspicious for afferent limb syndrome. 2. Normal cholangiogram.
3. Abnormal liver function tests are likely related to an afferent limb syndrome versus total-parenteral-nutrition-related cholestasis.

RECOMMENDATION(S):
1. If the patient has up-trending liver function tests, and this is thought to be mainly due to the afferent loop syndrome, may consider percutaneous drainage; however, if there is high suspicion for TPN-related cholestasis, would consider liver biopsy. Further, there is a possibility of drug-related liver injury from several antibiotics that the patient has recently been on. 2. Further recommendations per Dr. Basseri.
3. During the endoscopy, a narrow window for a PEG tube was localized. If the patient tolerates nasojejunal feeding tube and the patient and his daughter would like to pursue a PEG tube, this may be considered to be placed endoscopically. This may be performed with Dr. Basseri or with me.

SRINIVAS GADDAM, MD

SG/789745031/MEDQ D: 05/15/2018 T: 05/16/2018 Job#: 249460