


■ Letter to Editor

Bile Duct Dilatation

Safra Kanalı Genişlemesi

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I read with interest the article by Olcucuoglu et al. [1].The article titled "Retrospective Analysis of Unexplained Main Bile Duct Dilatation by Magnetic Resonance Cholangiopancreatography" was published in the 1/2024 issue of the journal. Congratulations to the authors for this article.

Dilatation of the common bile duct has become a common finding due to the increased frequency of abdominal ultrasonography for various reasons. There are non-invasive diagnostic methods such as magnetic resonance cholangiopancreatography (MRCP) and invasive diagnostic methods such as EUS (endoscopic ultrasonography) and ERCP (endoscopic retrograde cholangiopancreatography) that we can use for etiologic investigation after dilatation of the common bile duct is detected[2]. The most preferred method in daily practice is MRCP as it is a non-invasive method. Although advances in MR technology have improved the specificity of MRCP for visualization of biliary abnormalities, it still has limitations such as the need to use contrast and the inability to provide histologic diagnosis[3]. There is no standardized algorithm for the approach and choices after this stage. The diagnosis and/or treatment method to be chosen at this stage should be a personalized choice for the patient.

The most common causes of dilatation of the common bile duct of unknown origin reported in the literature are benign biliary stricture, choledocholithiasis, gallbladder stones, cholangiocarcinoma, and periampullary diverticulum. Another rare but missed cause of common bile duct dilatation is sphincter of oddi dysfunction (SOD). SOD is a clinical condition diagnosed with biliary pain, transaminitis and bile duct dilatation. Patients diagnosed after exclusion of other causes usually experience partial symptomatic relief with sphincterotomy. In this study, evaluation of 7 patients who could not be diagnosed with ERCP and EUS in terms of SOD may be considered.

In conclusion, it was emphasized that ERCP (Endoscopic Retrograde Cholangiopancreatography) may be the first choice in biliary stricture due to the necessity of histological diagnosis and biopsy, while EUS may be the first choice if choledocholithiasis is considered[4]. In daily practice, there is a need for algorithms that can guide the clinician in these choices and reduce unnecessary costs. These algorithms should include liver function tests, patient complaints, comorbidities, demographic characteristics such as age and gender, in addition to non-invasive imaging.

Referanslar

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Receved: 20.11.2024 accepted: 29.12.2024