Unusual breakage of a plastic biliary endoprosthesis causing an enterocutaneous fistula

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Abstract
Objective: The objective of our study was to illustrate a case of endoscopically placed biliary stent breakage. *Methods:* A 72-year-old woman with a prolonged history of cholangitis following laparoscopic cholecistectomy was referred to our institution 8 years ago. Dilatation of the intra- and extrahepatic biliary tree and a benign stricture at the cystic confluence were observed at US and endoscopic retrograde cholangiopancreatography (ERCP). A 12-F gauge plastic endoprosthesis was placed. In the absence of any symptoms, breakage of the stent was revealed 18 months later at plain radiology. Eight years later an enterocutaneous fistula occurred originating from a jejunal loop containing the indwelled distal part of the stent. Surgery was undertaken and the distal part of the stent removed with the perforated jejunal loop. The proximal part was successively endoscopically removed. *Conclusions:* Disruption of a biliary endoprosthesis is observed in patients in whom the stent is kept *in situ* for a long period or consequent to exchange. The removal and exchange is mandatory when the stent disruption is followed by cholangitis. In the current case, because of the absence of any symptoms the removal of the stent was not attempted. Immediate endoscopic removal of the prosthetic fragments seems to be the treatment of choice for replacement of a new stent.
Key words: Plastic endoprosthesis — Biliary — Breakage — Fistula
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A rare complication of laparoscopic adjustable gastric banding

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Abstract
The most common complications of laparoscopic gastric banding (LGB) are band dislocation, port problems, and leakage in the band system. We present a case of an aneurysmal dilatation of the balloon portion of the band by filling as a rare complication of LGB. A 53-year-old male patient with morbid obesity (body mass index 40 kg/m^2) was treated with LGB (adjustable Bioenterics gastric band). Six months after the operation there was no evidence of weight reduction. X-ray examination showed the band to be in the correct position. The port punction revealed no spontaneous fluid loss. The contrast filling of band demonstrated no signs of leakage but there was an abnormal dilatation of one part of the balloon. Only one filling segment of balloon was dilatated and the rest was empty. Two and a half years after the initial operation, we carried out laparoscopic band exchange. Six weeks later, the band was adjusted with 2 ml saline, and the patient reported successful reduction of food volume. He had lost 18 kg 3 months postoperatively. We conclude that band function requires careful intraoperative monitoring. In patients who do not lose weight after gastric restriction surgery, uncommon complications must also be considered.
Key words: Laparoscopic gastric banding — Obesity
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A breakthrough in cryosurgery

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Abstract
Liver cryosurgery is one of the treatment options for unresectable liver metastases. Indications for the use of this treatment instead of classic surgery are bilobar disease, location of the tumor at an irresectable anatomic site, and comorbid conditions of the patient. Possible complications of cryosurgery are hemorrhage, coagulopathy, pneumonia, pleural effusion, abdominal abscess, and bile fistula. We describe a patient in whom a hepatobronchial fistula developed after cryosurgery. The patient had cryosurgery because of an unresectable liver metastasis in a Dukes' C rectal carcinoma. More details are given in the case report. To our knowledge, a hepatobronchial fistula as a complication of cryosurgery has never been reported. It therefore should be added to the list of possible cryosurgery complications.
Key words: Hepatobronchial fistula — Cryosurgery — Complications of cryosurgery — Liver metastases — Liver abscess — Rectal carcinoma
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Cathamenial pneumothorax

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