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The Rendezvous Technique: An Increasingly More Acceptable Option for Choledocholithiasis Treatment^{☆,☆☆}



Técnica de rendez-vous: una alternativa cada vez más válida en el tratamiento de la coledocolitiasis

Dear Editor:

We have read with interest the article by Parra-Membrives et al.¹ about the recurrence of choledocholithiasis after laparoscopic exploration of the main bile duct. We congratulate

the authors for their extensive review, excellent track record in the laparoscopic approach of choledocholithiasis.

As they explain in their text, the choledocholithiasis approach is mostly done in 2 phases by means of ERCP and subsequent cholecystectomy, or by using a laparoscopic

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^{☆☆} Part of the content of this study was presented at the 32nd Congreso Nacional de Cirugía, 2018.

approach in a single stage. However, the single-stage approach using the rendezvous technique is presented as an effective alternative with excellent results.²

Noel et al.³ recently published the results of the Swedish national registry of biliary disease and ERCP comparing the rendezvous technique vs. ERCP, showing a lower complication rate (19.7 vs. 14 %, $P = .004$), post-procedure infection (4.4 vs. 2.3 %, $P = .028$) and especially lower rate of postoperative pancreatitis (6.4 vs. 3.2 %, $P = .003$) in favor of the rendezvous technique.

The difference observed in residual calculi after the procedure (5.5 vs. 0.6 %, $P < .001$) in favor of the rendezvous technique is also relevant.

In our experience, we have performed this procedure in patients with multiple failed ERCP, after pancreatitis due to the procedure itself, or impossible cannulation due to the presence of a duodenal diverticulum. Currently we have performed the procedure in 8 patients, and successfully in 6 (cannulation was impossible in 2, for whom the procedure was changed). The first of the patients required conversion to open surgery due to difficulties for cannulation. There were no cases of infection or pancreatitis. No recurrence of choledocholithiasis was observed in any of the patients during a follow-up period of 7–18 months.

The greatest difficulty in the procedure occurs during cannulation of the cystic duct with a flexible guidewire due to the Heister valves that, however, we have learned to surpass using a semi-rigid introducer.

Another of the major handicaps of the procedure is the longer surgical time compared to conventional cholecystectomy and coordination with digestive surgeons, which involves a reduction in the procedures to be performed by both services, number of patient hospitalizations, hospital stay and overall costs.

We believe that the rendezvous technique should be considered an effective and safe alternative for the treatment of choledocholithiasis, at least in patients with a high risk of post-ERCP pancreatitis or its failure. This method has had excellent results in published series, in addition to its low technical difficulty.

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