INDIVIDUALIZED DRAINAGE STRATEGIES IN MALIGNANT HILAR OBSTRUCTIVE JAUNDICE

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Background. Malignant hilar obstruction affects the branching biliary system and may isolate several hepatic segments, making drainage planning more complex than in distal obstruction. Persistent cholestasis and infection can compromise patient condition and delay definitive treatment. The central challenge is to identify which ducts should be drained and how the proposed intervention fits the intended surgical or palliative pathway. In potentially resectable disease, drainage decisions must be coordinated with the planned operation and the liver tissue that will remain. In unresectable disease, the priorities include relief of jaundice, control of infection and maintaining a route to further oncological treatment. Endoscopic and percutaneous approaches differ in their access to obstructed ducts and require careful selection rather than a uniform strategy. Stent choice also matters because subsequent revision or surgical planning may be affected by the initial intervention. These considerations make anatomical assessment, clear treatment intent and multidisciplinary coordination essential. An individualized review of contemporary drainage strategies is therefore relevant to both operative planning and palliation in malignant hilar jaundice.

Materials and methods. A narrative review of the ASGE guideline on malignant hilar obstruction and the ESGE biliary stenting guideline was undertaken. The review compares the roles of endoscopic drainage, percutaneous drainage and surgical decision-making. The conclusions represent a synthesis of published recommendations rather than findings from an original clinical series.

Results. ASGE guidance addresses drainage modality, drainage strategy and stent selection in malignant hilar obstruction. Cross-sectional assessment of duct involvement is central to choosing the segments to be drained. Preoperative planning must preserve the intended surgical pathway, whereas palliative drainage aims to relieve obstruction and support further cancer treatment. ESGE advises against routine preoperative drainage in malignant hilar obstruction and recommends uncovered self-expandable metal stents for palliative hilar drainage [2]. An irreversible stent strategy should follow a clear assessment of diagnosis and treatment intent. Endoscopic and percutaneous approaches require individualized selection according to duct accessibility and institutional expertise. Failure to achieve satisfactory decompression warrants reassessment and, where appropriate, a complementary drainage route. Patients considered for radical surgery require a multidisciplinary evaluation of tumour extent and operative fitness. Drainage success should be judged by symptoms, biochemical response, infection control and the need for repeat intervention.

Conclusion. Malignant hilar jaundice requires planned, segment-oriented drainage within a multidisciplinary surgical pathway. The distinction between preoperative and palliative intent is essential for selecting the drainage route and stent strategy.

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