

## Esophageal self-expandable metal stent for an anastomotic colorectal stricture

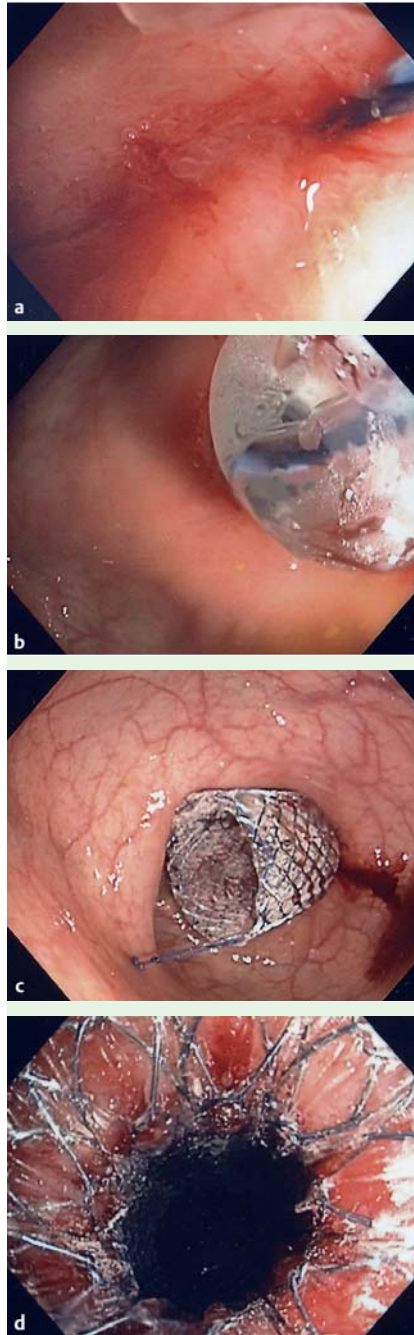
A 49 year-old woman with colonic inertia required total colectomy with ileorectal anastomosis in November 2009. She subsequently developed partial bowel obstruction requiring multiple balloon dilations of a pinpoint anastomotic stricture. A repeat endoscopy was performed and the stricture was first dilated up to 10 mm with a CRE balloon dilator (Boston Scientific, Natick, Massachusetts, USA; **Fig. 1 a, b**).

A fully covered, metal, 18 × 80-mm esophageal Bonastent (Standard Sci Tech Inc., Seoul, South Korea) was then deployed across the stricture (**Fig. 1 c, d**) under fluoroscopic guidance (**Fig. 2**). The patient tolerated the procedure well, without any complications.

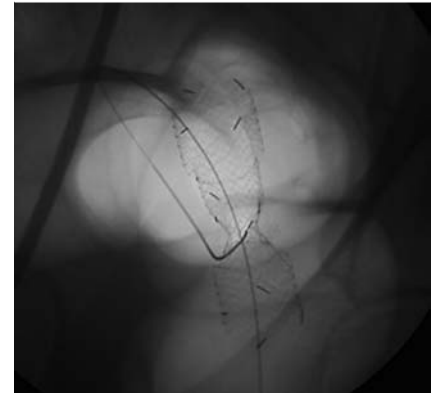
She was continuing to do extremely well when she returned for follow-up visits 1 month and 3 months later, with a barium enema showing a patent stent. She has declined to have the stent removed because she is finally symptom free.

This case is unusual in that an esophageal stent was used to treat a colonic stricture. In patients with advanced malignancies, colonic stenting can provide palliative care by relieving acute colonic obstruction [1]. More recently, self-expanding metal stents (SEMS) have been placed in patients with benign colorectal disease [2]. The use of SEMS may be associated with a longer lasting dilatation and a lower rate of recurrence in cases of anastomotic stricture [2].

The majority of the previously reported cases have used colonic stents, either covered or uncovered [3]. However, for rectosigmoid lesions, esophageal stents may be another useful option because they are covered and the relatively short distance from the anus offers greater mechanical advantage in terms of manipulation of the stents [3,4]. One clinical trial that compared the migration rates of several stents in malignant colonic strictures reported that the Bonastent had the lowest rate of migration. This was attributed to its larger diameter and flared ends [4].



**Fig. 1** Endoscopic view showing: **a** the wire placed across the anastomotic stricture; **b** the wire-guided balloon dilating the stricture; **c** the esophageal, covered, metal stent deployed across the stricture; and **d** a close-up of the stent inner lumen post deployment.



**Fig. 2** Fluoroscopic image of the metal stent deployed across the stricture showing a demonstrable waist at its center.

In conclusion, covered SEMS with flared ends can be used to relieve obstructions caused by anastomotic strictures. Further experience with these novel SEMS is required before they can be recommended for more generalized use.

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## Bibliography

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