Endoscopic ultrasound-guided hepatico-gastrostomy (EUS-HGS) has been indicated for failed endoscopic retrograde cholangiopancreatography (ERCP) [1, 2]. Recently, to obtain a longer duration of stent patency or avoid adverse events, EUS-HGS combined with antegrade stenting (EUS-HGAS) has been reported [3, 4]. In this procedure, an uncovered, self-expandable, metal stent (UCSEMS) is usually used to avoid stent dislocation. However, compared with a fully covered, self-expandable, metal stent (FCSEMS), longer stent patency may not be achieved [5]. A novel, double bare, partially covered, self-expandable metal stent (D-FCSEMS, EGIS Biliary Stent; S&G Biotech Inc., Yongin-si, Korea) has become available in Japan. This stent has low axial force compared with conventional FCSEMS, and high radial force compared with conventional UCSEMS. Therefore, this stent may be suitable for EUS-HGAS. Herein, we describe technical tips for EUS-HGAS using the D-FCSEMS (Video 1).

An 82-year-old man was admitted to our hospital with obstructive jaundice caused by advanced pancreatic cancer. Although ERCP was attempted, the duodenoscope could not be advanced into the duodenum owing to duodenal obstruction from pancreatic cancer invasion. Therefore, EUS-guided biliary access was attempted. First, the intrahepatic bile duct was punctured using a 19-gauge needle under EUS guidance, and contrast medium was injected (Video 2a). A guidewire was inserted into the biliary tract, followed by a balloon catheter. Next, contrast medium was injected to evaluate the biliary obstruction site. The cholangiograph showed the middle common bile duct to be obstructed (Video 2b). The intrahepatic bile duct and stomach wall were then dilated using the balloon catheter, and deployment of the D-FCSEMS stent (10 mm × 6 cm) from the lower common bile duct to the upper common bile duct was successfully performed (Fig. 2c). Finally, FCSEMS deployment was performed from the intrahepatic bile duct to the stomach without any adverse events (Fig. 2d).

Although additional cases are needed to determine the clinical impact of D-FCSEMS placement, the D-FCSEMS may be a suitable stent to use for EUS-HGAS.

Competing interests

None
The authors

Takeshi Ogura, Nobu Nishioka, Akira Miyano, Rieko Kamiyama, Kazuhide Higuchi

2nd Department of Internal Medicine, Osaka Medical College, Osaka, Japan

Corresponding author

Takeshi Ogura, MD

2nd Department of Internal Medicine, Osaka Medical College, 2-7 Daigakuchou, Takatsukishi, Osaka 569-8686, Japan

Fax: +81-72-6846532

oguratakeshi0411@yahoo.co.jp

References


Bibliography

DOI https://doi.org/10.1055/a-0767-6171
Published online: 23.11.2018
Endoscopy 2019; 51: E24 – E25
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at
https://mc.manuscriptcentral.com/e-videos

Fig. 2 Cholangiography. a The intrahepatic bile duct was punctured using a 19-gauge needle, and contrast medium was injected. b Obstruction of the middle common bile duct was seen. c Antegrade stent deployment from the lower to the upper common bile duct was performed using the double bare, partially covered, self-expandable, metal stent. d Endoscopic ultrasound-guided hepaticogastrostomy was successfully performed.