Rescue management of recurrent duodenal and biliary obstruction due to lumen-apposing metal stent distal migration and duodenal stent ingrowth

Endoscopic palliation of concomitant biliary and duodenal malignant obstruction can be challenging because of difficult access to the papilla. Endoscopic ultrasound (EUS)-guided biliary drainage (EUS-BD) via a choledochoduodenostomy created using a lumen-apposing metal stent (LAMS) is an innovative and relatively new technique for palliation of distal biliary malignancy in patients with an unreacheable papilla [1–3].

We present the case of a 59-year-old woman with gastric outlet obstruction (GOO) and jaundice with an unresectable pancreatic cancer causing duodenal obstruction that had previously been treated with EUS-guided choledochoduodenostomy (EUS-CD) using an electrocautery-tipped LAMS (EC-LAMS; Hot Axios, 6 × 8 mm; Boston Scientific, Natick, Massachusetts, USA) and placement of a duodenal self-expanding metal stent (SEMS; WallFlex Duodenal, 22 × 60 mm; Boston Scientific) (Fig. 1; Video 1).

The patient was readmitted 5 months after this procedure with fever and recurrence of her jaundice and GOO symptoms. Contrast-enhanced computed tomography (CT) scan showing the electrocautery-tipped lumen-apposing metal stent (EC-LAMS) that has migrated into the duodenal self-expanding metal stent (SEMS).
mography (CT) scanning showed gastric distension, dilated intrahepatic biliary ducts, and biliary LAMS migration into the proximal flange of the duodenal stent (Fig. 2). After the LAMS had been removed endoscopically (Fig. 3), the common bile duct (CBD) was cannulated in antegrade fashion through the transbulbar fistula and a double-pigtailed plastic stent (7 Fr \times 5\, \text{cm}) was placed into the CBD. A duodenal SEMS was then placed coaxially to the previous one to guarantee duodenal stent patency. After 15 days, duodenal stent patency was confirmed and the biliary plastic stent was replaced with a fully covered SEMS (40 \times 10\, \text{mm}), with the distal flange passing through the duodenal stents mesh (Fig. 4). No further recurrence occurred during follow-up.

Our report suggests that the presence of a choledochoduodenostomy allows for successful endoscopic management of concomitant biliary and duodenal malignant obstruction, with effective biliary drainage being achieved.

References


Competing interests

None

The authors

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DOI https://doi.org/10.1055/a-0836-2447
Published online: 5.3.2019
Endoscopy 2019; 51: E118–E119
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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