Stents must be of a sufficient length to prevent their migration into the abdominal cavity after endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS) [1, 2]. Although a self-expandable metal stent (SEMS) with a long intragastric portion can occasionally migrate to the esophagus, this hardly ever leads to severe complications. However, we present here a case of mediastinitis due to perforation caused by a SEMS.

A 75-year-old woman presented with intermittent vomiting for 2 days. She had undergone EUS-HGS 3 months previously for hilar biliary obstruction due to recurrent pancreatic cancer after pancreaticoduodenectomy. Two metal stents were used in the procedure: one was inserted into the hilar biliary obstruction site to bridge the right and left hepatic ducts (arrowhead); the second was placed from intrahepatic bile duct segment 2 to the stomach (arrow). The length of the intragastric portion of the stent was about 7 cm. The dotted arrow shows a metal stent placed for afferent loop syndrome.

After introducing a gastroscope, we pushed the SEMS back into the stomach using biopsy forceps and identified the site of perforation (►Fig. 3a; ►Video 1). We closed the perforation site using an over-the-scope clip (Ovesco Endoscopy GmbH, Tübingen, Germany) with the simple suction method because it was difficult to grasp both edges of the site using the dedicated forceps (►Fig. 3b). Subsequently, argon plasma coagulation was used to trim an intragastric portion of the SEMS to prevent it penetrating the esophageal wall again. Radiographic imaging showed no extravasation of contrast medium and revealed closure of the perforation site 12 days later. The patient recovered well.
A long stent carries a possible risk of perforation and mediastinitis, as presented in our case; therefore, every endoscopist should consider this complication when using a long SEMS for EUS-HGS. Development of new SEMS designs is mandatory to avoid such complications in the future.
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