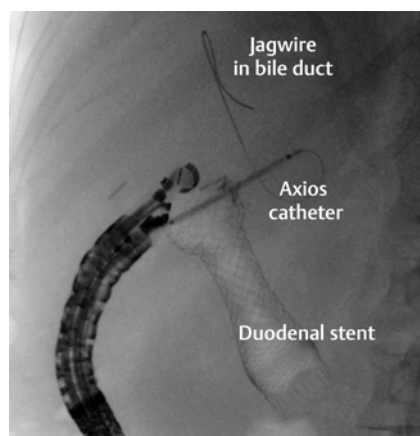
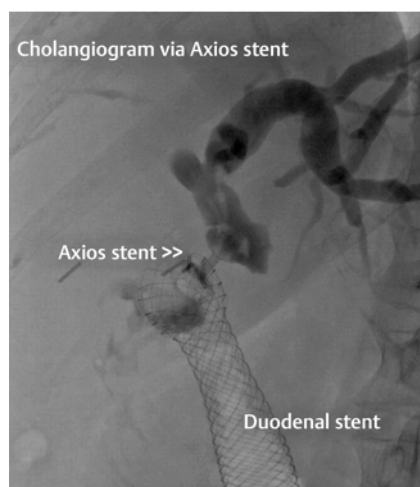


Endoscopic ultrasound-guided placement of biliary lumen-apposing metal stent through a duodenal stent

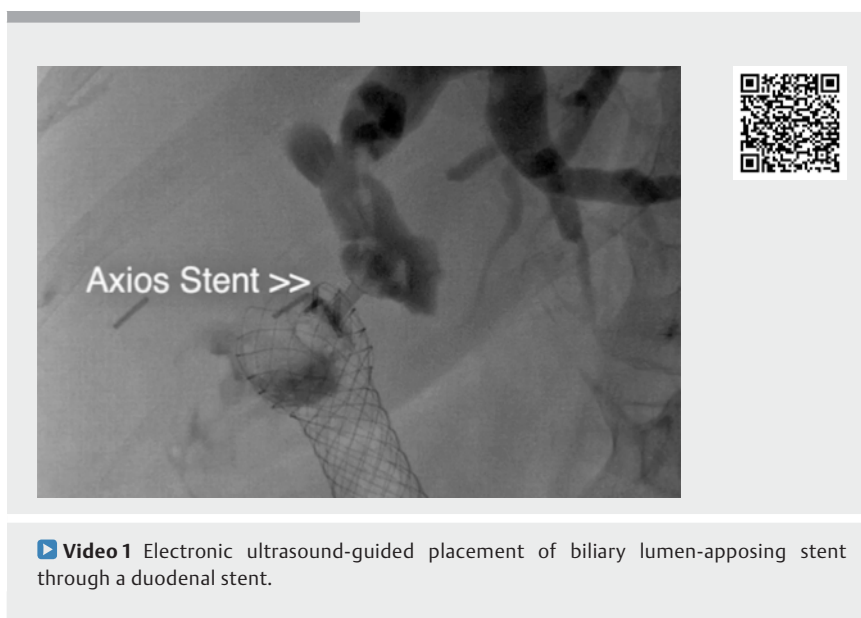


► **Fig. 1** AXIOS catheter through a duodenal stent, fluoroscopic view.



► **Fig. 2** Cholangiogram via lumen-apposing metal stent, placed through duodenal stent.

Endoscopic management of a malignant biliary obstruction becomes a significant challenge in the setting of an existing duodenal stent [1]. Progressive malignancy often causes stenosis of the duodenal stent, which renders it impassable by a duodenoscope. Options for biliary decompression include percutaneous drainage or endoscopic ultrasound (EUS)-guided choledochoduodenostomy or hepaticogastrostomy. We describe the



► **Video 1** Electronic ultrasound-guided placement of biliary lumen-apposing stent through a duodenal stent.

case of an EUS-guided choledochoduodenostomy using a lumen-apposing metal stent (LAMS) through the struts of an existing duodenal stent (► **Video 1**).

A 61-year-old woman with a pancreatic mass and obstructive jaundice had a covered metal stent placed at endoscopic retrograde cholangiopancreatography (ERCP). Unresectable pancreatic adenocarcinoma was subsequently confirmed, and she underwent chemotherapy. She eventually developed a gastric outlet obstruction related to duodenal stenosis. A duodenal stent was placed. During enteral stent placement, the existing covered biliary stent migrated out of the bile duct. The ampulla was not accessible via the enteral stent. The patient redeveloped obstructive jaundice, and options for drainage in the setting of the duodenal stent were discussed. The patient preferred EUS-guided choledochoduodenostomy.

The proximal end of the enteral stent was seated within the duodenal bulb. For visualization of the bile duct, the echoendoscope was placed into the proximal end of the stent. The bile duct

measured 18 mm. The stent caused significant artefacts that made visualization of the bile duct challenging. Electrocautery (pure cut, 100 W) was used and an 8-mm × 8-mm LAMS (Hot AXIOS) was placed through the proximal struts of the enteral stent into the bile duct. A 0.035-in guidewire was placed to secure the position (► **Fig. 1**). A combination of sonographic, direct, and fluoroscopic guidance was used to deploy the stent. Immediate biliary drainage was noted. A cholangiogram performed via the LAMS confirmed adequate stent position (► **Fig. 2**). The patient was discharged for ongoing palliative care two days later. Her biliary obstruction improved, however she died of advanced disease two months later.

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Competing interests

The authors declare that they have no conflict of interest.

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