A 95-year-old man with locally advanced gastroesophageal junction cancer diagnosed 2 months previously was referred for consideration of stent revision due to recurrent dysphagia. The patient had undergone stent treatment before, complicated by failure to advance a conventional applicator system through the short but tight and sharply angulated malignant stricture. Therefore, on that occasion, a 60-×-10-mm uncovered gastro-duodenal through-the-scope (TTS) stent was placed.

Recent endoscopy excluded stent migration, but the proximal stent end barely bridged the stricture and appeared partially tilted, giving rise to an almost 90° angle to the esophageal axis, consistent with the clinical impression of poor stent function (▶Fig. 1a). A decision was therefore made to perform stent-in-stent revision to extend the stent, placing another stent into the more proximal part of the esophagus. To this end, a 35-inch stiff guidewire (Jagwire; Boston Scientific) was preinserted into the stomach after endoscopic passage through the stent, which thus excluded threading through the stent meshes. However, during advancement of the applicator system of the 100-×-20-mm partially covered self-expanding metal stent (SEMS; Taewong Medical), resistance was noted, with stent and guidewire deformation apparent on endoscopy and fluoroscopy (▶Fig. 1b, ▶Fig. 2a). As a novel endoscopic bailout for this rare situation, we utilized endoscopic countertraction after parallel reinsertion of the gastroscope by grasping the proximal stent (▶Fig. 1c, ▶Fig. 2b). The scope with the grasped stent was kept under tension to straighten the stent and allow axial alignment. At the same time, the applicator system was cautiously advanced with initial judicious to-and-fro movements until resistance was no longer encountered (▶Fig. 1d, ▶Fig. 2c; ▶Video 1). Finally, the procedure...
dure was successfully finished with ade-
quately stent-in-stent extension achieved.
Esophageal and/or gastroesophageal
stenting is usually straightforward, with
high reported technical success rates at
primary and/or secondary deployment
[1, 2]. Notwithstanding, however, isolat-
ed tricky clinical situations may arise,
and this novel approach utilizing endo-
scopic countertraction might be instru-
mental in overcoming such occasional
challenges [3].

Competing interests

The authors declare that they have no con-
ict of interest.

References

Esophageal stenting for benign and malig-
nant disease: European Society of Gastroin-
testinal Endoscopy (ESGE) Clinical Guideline.
Endoscopy 2016; 48: 939–948
Esophageal self-expandable metallic stents
– indications, practice, techniques, and
complications: results of a national survey.
Gastrointest Endosc 1997; 45: 360–364
[3] Hindy P, Hong J, Lam-Tsai Y et al. A compre-
hensive review of esophageal stents. Gas-
troenterol Hepatol (N Y) 2012; 8: 526–534

Bibliography

Endoscopy 2021; 53: E303–E304
DOI 10.1055/a-1270-6418
ISSN 0013-726X
published online 8.10.2020
© 2020. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14,
70469 Stuttgart, Germany

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
duly accessible online.

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