A 54-year-old woman presented with a 1-month history of jaundice. Abdominal CT showed a perihilar hypodense mass measuring 21 × 16 mm in diameter with dilated bilateral intrahepatic bile duct (IHD). Hilar cholangiocarcinoma was diagnosed and palliative biliary drainage was scheduled. Endoscopic ultrasound (EUS)-guided hepaticogastrostomy (EUS-HGS) was performed with the patient under general anesthesia. A linear echoendoscope along with a 19-gauge EUS-FNA needle, a 0.025-inch guidewire, a 6-French cystotome, and serial bougie dilators up to 8.5 French were used. A 120-mm partially covered stent with distal flared end (Gibbore biliary stent; Taewoong Medical Co., Ilsan, Korea) was used to bridge the left IHD and stomach using the extra-scope channel deployment technique. The proximal end was successfully placed into the left IHD, but the distal end unfortunately displaced into the peritoneal cavity. We immediately converted EUS-HGS to exploratory laparotomy (▶ Video 1). The displaced distal end of the HGS stent and a hole on the serosal side of the stomach were identified (▶ Fig. 1). The distal end of the HGS stent was placed back into the stomach (▶ Fig. 2) and sutured to the stomach wall. Surgical hepaticogastrostomy was then successfully performed with the HGS stent. No postoperative adverse events occurred. The patient resumed a regular diet on day 4 and was discharged on day 7. She has been well without a need for biliary reintervention during 15 months of follow-up.

Stent migration, either as an early event during stent deployment [1] or as late migration due to stent shortening, occurs in about 2% to 3% of cases [2]. Migration can be a fatal complication of EUS-HGS.
Immediate stent migration can be treated with various techniques such as tandem stent placement [3], surgical removal [4], or endoscopic retrieval [5]. With the present case, we report surgical hepaticogastrostomy as another technique to resolve early HGS stent migration.

**Endoscopy_UCTN_Code_CPL_1AL_2AD**

### Competing interests

The authors declare that they have no conflict of interest.

**The authors**

Passakorn Sodarat¹, Thanawat Luangskrerk²,³, Pradermchai Kongkam²,³, Orathai Seabmuangsai¹, Chatchawan Wichiramatharuch¹

1 Department of Surgery, Roi-Et Hospital, Ministry of Public Health, Thailand
2 Gastrointestinal Endoscopy Excellence Center and Division of Gastroenterology, Department of Medicine, Faculty of Medicine, Chulalongkorn University and King Chulalongkorn Memorial Hospital, Thai Red Cross Society, Bangkok, Thailand
3 Pancreas Research Unit, Department of Medicine, Faculty of Medicine, Chulalongkorn University, Bankgok, Thailand

**Corresponding author**

Pradermchai Kongkam, MD
Gastrointestinal Endoscopy Excellence Center, Pancreas Research Unit, Department of Medicine, Chulalongkorn University and King Chulalongkorn Memorial Hospital, Thai Red Cross Society, 1873 Rama 4 Road, Pathumwan, Bangkok, Thailand

Fax: +66-2-652-4219
kongkam@hotmail.com

### References


### Acknowledgements

Funding information: Pancreas Research Unit, Faculty of Medicine, Chulalongkorn University, Health Systems Research Institute (HSRI), grant number HSRI 62-050.

**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](https://mc.manuscriptcentral.com/e-videos)