A 42-year-old woman presented with a 5-year history of abdominal distension, abdominal pain, and emesis, which became worse after she began eating a little more. Gastrointestinal barium examination detected a deformed pylorus (▶ Fig. 1a). Subsequently, a gastroduodenoscopy was performed, which revealed that the outlet of her stomach lay on the lesser curvature side of the gastric angle, with a blind end at the antrum (▶ Fig. 1b). We therefore suggested to the patient that she undergo surgery; however, she declined to undergo such treatment, preferring instead an endoscopic method to treat her problems. In the end, we decided to attempt, with the patient’s informed consent, an endoscopic magnet-assisted gastrojejunostomy (▶ Video 1).

Firstly, two ring-shaped magnets (16-mm diameter) with attached fixing strings were placed in succession into her jejunum and stomach (▶ Fig. 2a,b). After several attempts to adjust their position under fluoroscopic guidance, the two magnets attracted perfectly and were then stabilized by the string (▶ Fig. 2c,d). After 1 week with the magnets in place, a superficial ulcer developed under the compression of the magnets (▶ Fig. 2e). We extracted the magnets after another 2 weeks (▶ Fig. 2f), leaving behind a stenotic fistula. We then used a dilation balloon to enlarge the fistula (▶ Fig. 3a,b) and put in a 16×20-mm lumen-apposing metal stent (▶ Fig. 3c). A subsequent endoscopy and barium examination showed that this manually built channel was unobstructed (▶ Fig. 3d–f), with no leakage of barium. During 1 month of follow-up, the patient gained relief of her symptoms, without any complications of the procedure. With advancements of technology, endoscopic methods, such as magnets, natural orifice transluminal endoscopic surgery (NOTES), and endoscopic ultrasound (EUS)-guided techniques, are able to create a gastrointestinal anastomosis without the requirement for surgery [1]. Moreover, the creation of magnet-assisted gastroenteric anastomoses has been demonstrated to be feasible and safe for malignant gastric outlet obstruction [2]. Our experience indicates that this method may also result in good outcomes for patients with benign anatomic abnormalities.

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Competing interests

The authors declare that they have no conflict of interest.

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