Rescue endoscopic treatment with completion by radical surgery following misplacement of a partially covered metal stent in an anastomotic fistula post-Lewis Santy esophagectomy

Curative management of esophageal adenocarcinoma is based on esophagectomy. One of the main complications is anastomotic fistula (30%) [1], which is responsible for significant postoperative morbidity and mortality, as well as reduced survival [2]. In recent years, endoscopic treatment of anastomotic fistulas has become a valuable option, enabling closure of the fistula and a reduction in the mortality rate [3, 4].

We report the case of a 55-year-old patient who underwent a Lewis Santy esophagectomy for esophageal adenocarcinoma. The patient developed an anastomotic fistula with a pleural abscess requiring antibiotics, thoracic drainage, and placement of a partially covered self-expandable metal stent (PCSEMS) to cover the fistula. However, the thoracic drainage remained highly productive and an endoscopy revealed migration of the stent’s distal flange, with embdenment into the fistula (▶ Fig. 1 and ▶ Fig. 2). After several unsuccessful attempts at endoscopic removal, the patient was transferred to our center. He presented to us with a chronic pleural infection and total dependence on parenteral nutrition. An endoscopic procedure to re-establish digestive continuity was planned. The lower pole of the fibrin-wrapped stent and a productive fistulous orifice were identified (▶ Fig. 3).

The FCSEMS was removed after 3 months, but the PCSEMS remained irremovable. After discussion with the surgical team, it was decided to try the stent-in-stent technique [5], and a new FCSEMS was inserted inside the PCSEMS (▶ Fig. 4). A further endoscopy was performed 2 weeks later, at which the FCSEMS was
removed without difficulty, but the PCSEMS remained embedded. Given the impossibility of endoscopic PCSEMS removal, it was decided that surgical management would be required and the patient underwent surgical removal of the PCSEMS and coloplasty.

**Conflict of Interest**

The authors declare that they have no conflict of interest.

**References**


**Bibliography**

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**Fig. 3** Endoscopic images from the first procedure performed in our center showing: a the fistulous orifice and incarceration of the distal flange of the partially covered self-expandable metal stent (PCSEMS); b the gastroplasty and passage of the PCSEMS through the fistulous orifice.

**Fig. 4** 3 D reconstruction from the CT scan performed after placement of a fully covered self-expandable metal stent (FCSEMS) within the partially covered self-expandable metal stent (PCSEMS) for the stent-in-stent technique.

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