A 40-year-old man, a long-term smoker, presented with progressively increasing dysphagia associated with loss of appetite and weight. The general physical and systemic examination was normal. Routine investigations, including hemogram, blood biochemistry and a chest radiograph were also normal.

Upper gastrointestinal endoscopy revealed a polypoidal growth in the mid-esophagus. The endoscope could not be negotiated beyond the growth. Histopathological examination of the endoscopic biopsies was suggestive of squamous cell carcinoma. The patient was treated with radiotherapy. However, the dysphagia persisted and patient was referred to us for insertion of a self-expanding metallic stent (SEMS). After obtaining informed consent, a nitinol SEMS (11 cm Choo stent, M. I. Technical, Seoul, South Korea) was placed across the stricture, which resulted in marked relief of dysphagia.

Fifteen months later, the patient reported back with progressively increasing dysphagia. An upper gastrointestinal endoscopy revealed that the SEMS had collapsed at places, and the wire mesh was broken with ingrowth of tumor (Fig. 1). Under fluoroscopic and endoscopic guidance, a 14 cm nitinol SEMS (Choo stent, M. I. Technical, Seoul, South Korea) was placed within the previously placed stent (Fig. 2).

There was marked relief of dysphagia and the patient remained asymptomatic after 5 months of follow-up.

SEMS are commonly used for palliation in patients with malignant dysphagia and typical complications may be acute (including hemorrhage, ulceration, perforation or fistula, compression of the trachea, malposition, delivery system entrapment, stent dislodgment) or chronic (gastroesophageal reflux disease/recurr-
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Endoscopy 2009; 41: E170 – E171
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