

Endoscopic retrieval of a migrated esophageal stent in the cecum

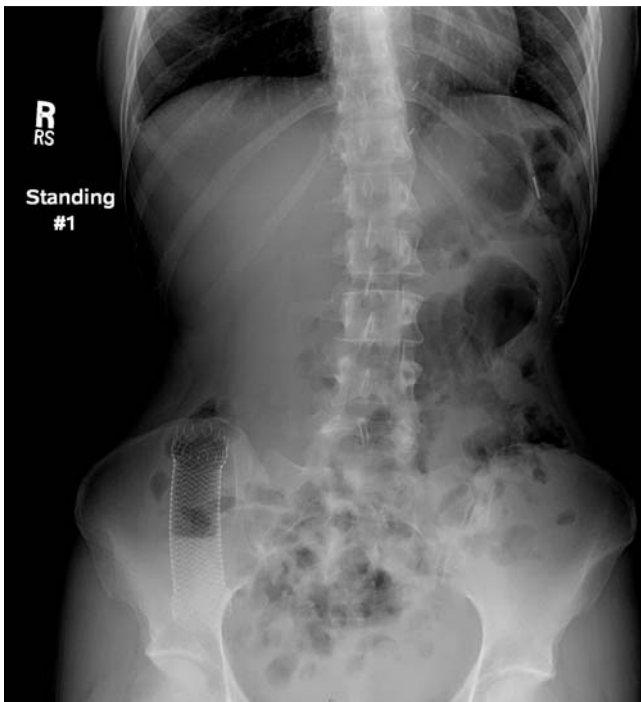


Fig. 1 Upright abdominal plain film showing stent in right lower quadrant; no dilated loops of bowel or free intraperitoneal air is seen.



Fig. 2 Abdominal computed tomography showing the metallic stent within the cecum and ascending colon.



Fig. 3 Wallflex stent in the ascending colon.

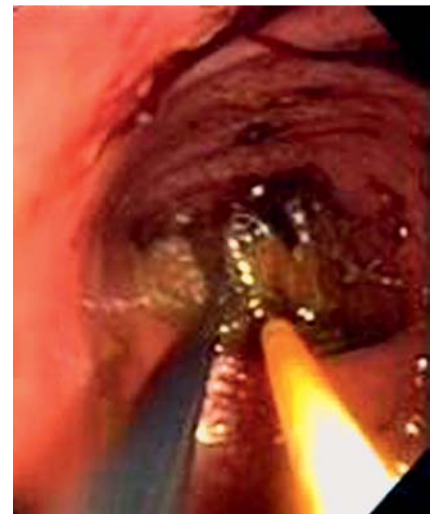


Fig. 4 A combination of rat tooth forceps (black) and biopsy forceps (orange) is used to grab opposite ends of the stent to allow for better control.

A 38-year-old woman with a history of total gastrectomy in 2006 for adenocarcinoma presented with complaints of severe right-sided abdominal pain and dysphagia. The patient had experienced progressive intolerance to solid foods and a 50-lb weight loss over 1 year. Work-up at an outside institution revealed recurrent cancer at the esophago-enteric anastomosis, and a 23 mm × 100 mm Wallflex partially covered esophageal stent (Boston Scientific, Natick, Massachusetts, USA) was placed at that time. The patient noted rapid recurrence in dysphagia and concomitant abdominal discomfort after 2 days. An abdominal radiograph showed the stent in the right lower quadrant with no dilated loops of bowel or free intraperitoneal air (● Fig. 1).

An abdominal computed tomography scan showed the stent in the ascending colon (● Fig. 2).

After 72 hours of conservative management, which failed, the decision was made to pursue endoscopic retrieval. Using an Olympus CF-H180 colonoscope (Olympus Corp., Tokyo, Japan), we attempted to place a snare around the stent in the ascending colon (● Fig. 3) but could not encase it circumferentially as the distal end flared to 28 mm.

A rat tooth forceps was then utilized to draw the stent into the left colon. The stent could not be withdrawn further due to sharp turns in the descending colon. A double-channel upper endoscope (Olympus GIF-2TQ160) was advanced, and a rat tooth and biopsy forceps were used



Fig. 5 Retrieved Wallflex stent.

simultaneously to grab opposite ends of the stent (● Fig. 4).

After a total of 70 minutes of maneuvering, the stent was withdrawn from the rectum (● Fig. 5), and the patient recovered without issue.

Placement of self-expandable stents is an accepted option for malignant esophageal obstruction after gastric surgery [1]. Migration is an uncommon, but known, complication of esophageal stent placement [2]. This case illustrates an extremely rare occurrence of a 100-mm long stent migrating through the small intestine into the colon, and highlights a successful endoscopic retrieval technique using a combination of endoscopic tools.

Competing interests: None

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Bibliography

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