Endoscopic removal of a fractured partially covered Evolution esophageal stent

Self-expanding metal esophageal stents have been increasingly utilized in the treatment of benign strictures that are refractory to dilation [1–3]. The radial force of the stent and resulting tissue hyperplasia often make subsequent stent retrieval difficult. Complications range from a need for multiple repeat procedures to perforation requiring surgical intervention [4,5].

A 67-year-old man with a history of esophageal carcinoma treated with esophagectomy and gastric pull-up developed dysphagia related to a benign anastomotic stricture. Endoscopic balloon dilation did not alleviate his symptoms and an Evolution stent (EVO-20-25-10-E, Cook Medical, Winston-Salem, North Carolina, USA) was deployed across the stricture. However, 2 months following stent placement, the patient developed dyspnea, and a computed tomography (CT) scan demonstrated edematous tissue surrounding the stent and causing a mass effect on the trachea (Fig. 1). Two Polyflex (M00514300, Boston Scientific, Natick, Massachusetts, USA) stents were deployed to facilitate mucosal pressure necrosis and removal of the Evolution stent, but this was unsuccessful. The upper portion of the Evolution stent fractured during a removal attempt and the patient developed stridor requiring intubation.

The patient was transferred to us. We performed flexible endoscopy using a 6-mm channel endoscope (Olympus XTD160, Olympus America Inc., Center Valley, Pennsylvania, USA) equipped with three rat tooth forceps to pull the uncovered portion of the stent into the channel, causing partial collapse of the proximal stent. We then used argon plasma coagulation to cut the remaining embedded upper flanges, following which our otolaryngology colleagues introduced a Weerda distending diverticuloscope (Karl Storz, Tuttingen, Germany; 12067b, length 24 cm). Heavy alligator forceps were deployed through a rigid 4-mm endoscope to elevate the stent circumferentially until it was freed from the mucosa (Fig. 2, Video 1). At the 3-month follow-up, the gastroesophageal anastomosis remained patent (Fig. 3). We recommend caution before deploying a partially covered metal stent in the esophagus for the treatment of benign strictures because its successful removal has a narrow window of safety.

Endoscopy_UCTN_Code_TTT_1AO_2AZ

Competing interests: None
References
5 Hirdes MM, Vleggaar FP, Van der Linde K et al. Esophageal perforation due to removal of partially covered self-expanding metal stents placed for a benign perforation or leak. Endoscopy 2011; 43 (Suppl. 02): 156–159

Bibliography
DOI http://dx.doi.org/10.1055/s-0032-1308921
Endoscopy 2012; 44: E378–E379
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
R. Soetikno (Chief of Endoscopy)
Veterans Affairs Palo Alto Health Care System
3801 Miranda Ave, GI111
Palo Alto, CA 94304
USA
Fax: +650-849-0255
roy.soetikno@va.gov