Endoscopic ultrasound (EUS)-guided duodenogastroenterostomy: why not do it from the other side?

A 76-year-old woman, with previous resection of a metastatic mixed adenocarcinoma-neuroendocrine tumor of small-bowel origin presented with gastric outlet obstruction. Abdominal computed tomography revealed a submucosal mass in the third portion of the duodenum, with upstream gastroduodenal dilatation. There was intimate contact between the wall of the fourth duodenal portion and the stomach (Fig. 1).

Retrograde gastroenterostomy was performed as follows, with the patient under general anesthesia. A forward-viewing curved linear endoscopic ultrasound (EUS) scope (TGF-UC180J; Olympus) was advanced distally from the stenosis and proximally to the ligament of Treitz, with the tip of the echoendoscope apposed to the gastric wall under fluoroscopic view. Instillation of water into the stomach via a nasogastric tube aided echo visualization. Direct puncture into the stomach was done with a standard 19-gauge fine-needle aspiration (FNA) needle and a gastrogram was obtained using contrast under fluoroscopic guidance (Fig. 2a). A 0.025-inch guidewire (450 cm, angled-tip VisiGlide; Olympus) was advanced into the stomach and looped once (Fig. 2b). The echoendoscope was withdrawn and re-introduced to grasp the gastric portion of the wire, allowing control of both ends. Then the echoendoscope was re-introduced over the duodenal portion of the guidewire and a 15-10 biflanged lumen-apposing stent (Axios; Boston Scientific) was advanced into the stomach (Fig. 3) and deployed without cautery or balloon dilation (Fig. 4a, 4b). The patient did well without adverse events.

Despite previous reports of EUS gastroenterostomies [1–4], to our knowledge this has never previously been performed from the duodenum to the stomach, as described here. This approach avoids puncture into the duodenal lumen, which has a small caliber and is mobile, and obviated the need for a targeting balloon [2]. In addition, the forward-viewing endoscope allows stent advancement without the need for tract dilation, minimizing the risk of luminal leakage. Although the gastric wall may tent away during stent advancement, having both ends of the wire under pressure allows this to be overcome.

Endoscopy_UCTN_Code_TTT_1AS_2AG
**Competing interests:** Dr. Baron is a consultant and speaker for Boston Scientific and Olympus.

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**References**


**Bibliography**

DOI http://dx.doi.org/10.1055/s-0034-1393650
Endoscopy 2015; 47: E594–E595
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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**Fig. 3** The echoendoscope was then reintroduced again over the duodenal part of the guidewire. Fluoroscopy shows the delivery system of the stent advanced into the stomach without cautery or balloon dilation.

**Fig. 4** After stent deployment. 

a Fluoroscopic image: the 15-10 biflanged lumen-apposing stent with both flanges in correct positions.

b Endoscopic image: gastric view of the gastroduodenostomy after stent deployment. Both ends of the wire are still in position.