An unusual case of migration of an esophageal stent for benign esophageal stricture

Fig. 1 Abdominal radiograph showing the stent within the pelvis.

Fig. 2 Sigmoidoscopic view showing the esophageal stent that had migrated into the rectum.

Fig. 3 The esophageal stent following its removal from the rectum.

A 38-year-old Hispanic man with a benign esophageal stricture presumed to be related to chronic acid exposure or toxic ingestion was treated with recurrent esophageal balloon dilations for refractory symptoms and eventually underwent esophagectomy with gastric pull-up and pyloromyotomy. His postoperative course was complicated by recurrent strictures at the esophagogastric anastomosis despite multiple dilations. A subsequent esophagogastroduodenoscopy demonstrated a benign-looking stricture. This was traversed after balloon dilation and a fully covered self-expandable metal stent (FCSEMS) was placed.

The patient experienced complete resolution of his dysphagia following FCSEMS placement; however, he did not attend for the stent removal procedure at 6 weeks. He presented back to clinic 12 weeks after stent placement with complaints of rectal pain and tenesmus. Abdominal radiography showed that the esophageal stent had migrated into the pelvis (**Fig. 1**). Rectal examination was notable for a palpable endoprosthesis. Flexible sigmoidoscopy was performed with extraction of the stent using rat-tooth forceps (**Fig. 2** and **Fig. 3**). A localized area of erythematous mucosa related to stent trauma was identified within the rectum.

Endoscopic esophageal stent placement for benign refractory strictures has evolved to provide long-term symptom control and relief of dysphagia in 90% of patients [1,2]. Stent migration is the most frequently recognized complication encountered following placement of FCSEMSs for this indication, occurring in 25%–39% of patients [2,3]. Stent anchoring techniques using clips, over-the-scope clips, or suturing devices to fix the upper flare of the stent have been shown to significantly decrease migration rates to as low as 13%–16% [4,5]. Extraction of migrated stents to prevent hemorrhage, perforation, or obstruction related to stent impaction is advocated.

The current case report describes a rare complication of an esophageal stent, namely migration through the entirety of the gastrointestinal tract and into the rectum. Although the majority of stents become entrapped within the stomach, the presence of a pyloromyotomy in our patient may have predisposed to distal migration of the stent [6,7]. Prompt recognition and treatment of migrated stents may help to decrease stent-related adverse events.

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