A 53-year-old man with chronic pancreatitis presented with abdominal pain and sepsis. Imaging revealed a liver abscess secondary to distal biliary obstruction. Following drainage of his abscess, the patient underwent endoscopic retrograde cholangiopancreatography (ERCP) with placement of a fully covered metal biliary stent across a 2-cm suspicious shouldered and irregular low common bile duct stricture. A pancreatic head malignancy was suspected at ERCP and on computed tomography (CT) imaging. The regional specialist hepatobiliary multidisciplinary team (MDT) recommended endoscopic ultrasound with fine needle aspiration (EUS-FNA).

EUS-FNA was difficult because of the changes of severe chronic calcific pancreatitis, duodenal stenosis, increased pancreatic head vascularity, and metal stent artefact. Five needle passes were made with a 22-gauge needle (Boston Scientific, Marlborough, Massachusetts, USA) using standard technique. Cytology was consistent with pancreatitis, with no evidence of malignancy.

A routine chest radiograph 6 months later revealed a new linear density in the heart (▶Fig. 1). The interim abdominal CT imaging was re-reviewed (▶Fig. 2). Although not recognized at the time, owing to the highly calcified pancreas, it became clear that a fractured EUS-needle tip had migrated from the duodenal wall into the epigastrium (▶Fig. 3), then through the diaphragm and into the left ventricle. On a subsequent chest radiograph, the needle had disappeared and a further CT scan revealed that it had migrated to the aortic bifurcation (▶Fig. 4a).

The needle was retrieved endovascularly via bilateral common femoral artery access. It was first snared from above with a protective occlusion balloon placed below in the left iliac artery (▶Fig. 4b). The balloon was deflated, the needle was snared from below and was then removed through the left groin sheath (▶Fig. 4c; ▶Video1). The patient made an uneventful recovery after the procedure.

Endoscopic needle fracture has been previously described in the upper gastrointestinal tract [1, 2] and in a bronchoscopy setting [3]. Fractured metal sharps such as orthopedic fixation wires have been known to migrate into the arterial circulation, including into the heart [4].

This is the first known case of an endoscopic needle migrating intra-arterially.

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Competing interests

None
Fig. 2 Axial computed tomography (CT) scan showing the needle (red arrow) that was not identified originally among the pancreatic calcifications.

Fig. 3 Obliquely reformatted computed tomography (CT) images showing: a the needle extending through the duodenal wall; b the needle having moved to the epigastrium.
Fig. 4  Further imaging shortly before and during removal of the needle.  

a A volume-rendered computed tomography (CT) angiogram showing the needle at the aortic bifurcation.  
b The needle was snared from above with balloon occlusion below.  
c The needle was snared from below and was removed through a sheath.

References


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Bibliography

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