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; ▶Video 1). 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.

Endoscopy_UCTN_Code_CPL_1AJ_2AZ

Competing interests

None
The Authors

Edward Lake¹, Joanne Puleston², Finn Farquharson¹

¹ Department of Radiology, Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK
² Department of Gastroenterology, Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK

Corresponding author

Edward Lake, MD
Department of Radiology, Manchester Royal Infirmary, Grafton Street, Manchester, M13 9WL, UK
edwardlake@yahoo.com

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.
References


[4] Leonardi F, Rivera F. Intravascular migration of a fractured cerclage wire into the left heart. Orthopedics 2014; 37: e932 – e935

Bibliography

DOI http://dx.doi.org/10.1055/s-0042-123704
Endoscopy 2017; 49: E70–E72
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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.

▶ 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.