Endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS) has been developed as an alternative method for biliary drainage after failed endoscopic retrograde cholangiopancreatography (ERCP) [1]. EUS-HGS may be indicated for patients with advanced disease stages [2, 3]. However, following recent developments in chemotherapy, such as FOLFIRINOX (folinic acid + fluorouracil + irinotecan + oxaliplatin) [4], longer survival may be obtained; therefore, longer stent patency is clearly required.

Recently, EUS-HGS combined with antegrade stent placement has been reported for this purpose [5]. For this technique, to prevent stent dislocation or misplacement due to stent shortening, a laser-cut-type, uncovered, metal stent may be preferred. However, if the angle of bile duct axis is acute, stent expansion may be insufficient due to low radial force. Therefore, EUS-guided access was attempted as a drainage method.

First, the intrahepatic bile duct was punctured using a 19-gauge fine-needle aspiration needle, and the guidewire was placed. Then, an ERCP catheter was inserted into the biliary tract, and the contrast medium was injected. On cholangiography, bile duct obstruction was seen in the middle common bile duct with a relatively tortuous axis (▶ Fig. 2). Therefore, a flexible uncovered metal stent (10 mm × 8 cm) was deployed in an antegrade fashion (▶ Fig. 3). Finally, EUS-HGS was performed using a partially covered metal stent (▶ Fig. 4).

The following day, full expansion of the flexible metal stent was confirmed on computed tomography (▶ Fig. 5).

A flexible stent may be clinically useful, not only for multi-stenting in a through-
the-stent technique under ERCP guidance, but also in EUS-HGS combined with antegrade stent placement.

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**Competing interests**

None

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