Endoscopic pancreatic stenting is benefi-
cial for patients with a variety of pancre-
atic conditions; however, proximal mi-
gregation of the stent occurs occasionally
and removal is technically demanding
[1, 2]. It is sometimes quite challenging
to pass stent-removal devices such as for-
ceps, baskets, and snares across a stric-
ture, particularly in cases in which the
migrated stent is located further away
from the pancreatic duct stricture [3].
We present an impressive case in which a
new endoscopic tapered sheath (Endo-
Sheather; Piolax, Inc., Kanagawa, Japan)
(Fig. 1) [4] contributed successfully to
the removal of a proximally migrated
stent in a patient with a distal stricture.
This novel device allowed the stricture to
be passed and devices to be inserted
easily through an indwelling outer sheath,
providing a bridge to the target
space even in the deep pancreatic tail.
An 84-year-old woman with a pancreatic
head intraductal tubulopapillary neo-
plasm developed abdominal pain caused
by a pancreatic duct stricture. Place-
ment of a 7 Fr plastic stent (7 cm) across the
stricture improved her symptoms. How-
ever, the pancreatic stent migrated be-
yond the stricture (Fig. 2). A conven-
tional balloon catheter failed to remove
the stent. None of the devices used to
grab the migrated stent could access the
proximal duct due to the severe stricture.
Therefore, the new endoscopic sheath,
with a tapered inner catheter tip to allow
easy passage across the stricture, was in-
serted into the pancreatic duct over a
0.025-inch guidewire. Only the inner
catheter was removed, leaving the outer
sheath near the target position. Subse-
quently, the retrieval basket was inserted
smoothly through the outer sheath to
reach the migrated stent. The migrated
stent was grasped with the basket and
successfully dragged out to the duode-
num without adverse events (Fig. 3,
Video 1).

Fig. 1. The endoscopic tapered sheath (EndoSheather; Piolax, Inc., Kanagawa, Japan).
(a) Tip calibers of the inner catheter and the outer sheath are similar. A 0.025-inch guidewire
is used with the inner catheter. Outer-sheath external diameter: 7.2 Fr (2.44 mm); interior
diameter: 6.2 Fr (2.06 mm). The outer-sheath tip has a radiopaque marker (blue arrowhead).
(b) A retrieval basket can be inserted through the outer sheath along the 0.025-inch guidewire.

Fig. 2. The proximally migrated stent was located away from the stricture (red arrowheads). Yellow arrows indicate the proximal head and the distal end of the migrated stent.
The new endoscopic tapered sheath was inserted deep into the pancreatic duct over a
0.025-inch guidewire. Blue arrowhead shows the radiopaque marker of the outer sheath.
This technique may be a useful option for removing a proximally migrated pancreatic stent that is beyond the stricture or deep in the pancreatic duct.

Competing interests

The authors declare that they have no conflict of interest.

Fig. 3 The retrieval basket reached the head of the migrated stent smoothly through the outer sheath. The migrated stent was successfully removed using the Lariat technique by grabbing the distal end of the stent. a Fluoroscopic image. b Endoscopic image.

Video 1 A new endoscopic tapered sheath contributed to the successful removal of a proximally migrated stent that was located away from the stricture.

Endoscopy_UCTN_Code_TTT_1AR_2AB

References


Bibliography

Endoscopy
DOI 10.1055/a-1792-2955
ISSN 0013-726X
© 2022. The Author(s).
This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

 Corresponding author

Michihiro Yoshida, MD, PhD
Department of Gastroenterology and Metabolism, Nagoya City University Graduate School of Medical Sciences, 1 Kawasumi, Mizuho-cho, Mizuho-ku, Nagoya 467-8601, Japan
mityoshi@med.nagoya-cu.ac.jp

The authors

Akihisa Kato1*, Makoto Natsume1*, Michihiro Yoshida1, Katsuyuki Miyabe2, Yasuki Hori1, Itaru Naitoh1, Kazuki Hayashi1

1 Department of Gastroenterology and Metabolism, Nagoya City University Graduate School of Medical Sciences, Nagoya, Japan
2 Department of Gastroenterology, Japanese Red Cross Aichi Medical Center Nagoya Daini Hospital, Nagoya, Japan

* These authors contributed equally to this work.