A 38-year-old woman with a history of total gastrectomy in 2006 for adenocarcinoma presented with complaints of severe right-sided abdominal pain and dysphagia. The patient had experienced progressive intolerance to solid foods and a 50-lb weight loss over 1 year. Work-up at an outside institution revealed recurrent cancer at the esophago-enteric anastomosis, and a 23 mm × 100 mm Wallflex partially covered esophageal stent (Boston Scientific, Natick, Massachusetts, USA) was placed at that time. The patient noted rapid recurrence in dysphagia and concomitant abdominal discomfort after 2 days.

An abdominal computed tomography scan showed the stent in the ascending colon (Fig. 2). After 72 hours of conservative management, which failed, the decision was made to pursue endoscopic retrieval. Using an Olympus CF-H180 colonoscope (Olympus Corp., Tokyo, Japan), we attempted to place a snare around the stent in the ascending colon (Fig. 3) but could not encase it circumferentially as the distal end flared to 28 mm.

A rat tooth forceps was then utilized to draw the stent into the left colon. The stent could not be withdrawn further due to sharp turns in the descending colon. A double-channel upper endoscope (Olympus GIF-ZTQ160) was advanced, and a rat tooth and biopsy forceps were used...
simultaneously to grab opposite ends of the stent (Fig. 4).

After a total of 70 minutes of maneuvering, the stent was withdrawn from the rectum (Fig. 5), and the patient recovered without issue.

Placement of self-expandable stents is an accepted option for malignant esophageal obstruction after gastric surgery [1]. Migration is an uncommon, but known, complication of esophageal stent placement [2]. This case illustrates an extremely rare occurrence of a 100-mm long stent migrating through the small intestine into the colon, and highlights a successful endoscopic retrieval technique using a combination of endoscopic tools.

**Competing interests:** None

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