Endoloop application for the removal of a self-expandable metallic stent (SEMS) in an esophagocolonic anastomotic stricture

Anastomotic strictures occur in 3% – 46.2% of patients after colonic reconstruction of the esophagus [1]. Self-expanding metal stents (SEMS) are increasingly considered for refractory or complex benign strictures of the esophagus [2]. Migration is a common complication and the stent should be removed to avoid gastrointestinal complications.

A 54-year-old man was referred to our department for dysphagia following esophagectomy with colonic interposition to treat an esophageal adenocarcinoma. On esophagoscopy, a 5-mm wide and 3-cm long stricture, corresponding to the esophagocolonic anastomosis at 25 cm from the incisors, could not be traversed. After five dilation sessions at 2-week intervals the patient was still dysphagic and a fully covered stent (HanaroStent, 80 mm in length; MI Tech, Seoul, Korea) was positioned. Because of the eversion of its distal edge and the risk of the stent getting caught in the tissue, it was rotated and then retrieved by utilizing the “lasso” stitch at the stent edge and pulling it against the endoscope. The whole assembly was subsequently removed under fluoroscopic control through the stricture without complications.

The removal of migrated SEMS is technically challenging and different methods have been reported, including the use of endoloops [3–5]. To our knowledge this is the first video report of a stent retrieved from an esophagocolonic anastomosis.

Competing interests: None

References
1 Yasuda T, Shiozaki H. Esophageal reconstruction with colon tissue. Surg Today 2011; 41: 745 – 753
2 Siersema PD. Stenting for benign esophageal strictures. Endoscopy 2000; 41: 363 – 373

Video 1
Removal of a migrated self-expandable metallic stent (SEMS) with endoloop application. The use of endoloops reduced the stent diameter and permitted its retrieval through an esophagocolonic anastomotic stricture.

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