The wide-caliber stent was chosen to allow for easy drainage of necrotic debris without risk of clogging of the stent and for repeated access to the walled-off area for direct endoscopic necrosectomy, if needed. The proximal aspect of the stent was deployed within the duodenal lumen. However, because of the limited diameter of the duodenum, the flared end and shaft of the stent occupied the entire duodenal lumen, resulting in duodenal obstruction. To overcome this mechanical obstruction, argon plasma coagulation (APC) was used at 60 Watts and 1 L/min flow to fenestrate the stent interstices (Video 1). The fenestrations provided a patent lumen through which food and the necrotic pancreatic contents could pass into the duodenum and onwards through the gastrointestinal tract.

The patient was restarted on an oral diet on the day following the procedure and was tolerating this well prior to discharge. He reported a rapid resolution of his symptoms, and repeat imaging at 6 weeks showed a significant reduction in the size of the WOPN (Video 1). The use of APC for trimming metal stents has been reported in a few cases [3,4]. Here we report a novel use of APC to fenestrate a metal stent and tailor it to the needs of a patient with an area of WOPN and altered gastrointestinal anatomy.

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Fig. 4 Endoscopic image of the fully covered self-expandable metal stent (FCSEMS) placed across the cystenterostomy (blue arrow), with the partially obstructed duodenal lumen visible through the fenestrated stent interstices (white arrow).

Fig. 5 Computed tomography (CT) scan images 6 weeks after fully covered, self-expandable metal stent (FCSEMS) placement showing: a (in axial view) a significant reduction in the size of the walled-off area of pancreatic necrosis (yellow arrow); b (in coronal view) the FCSEMS in position between the duodenum and the walled-off area (green arrow).

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