Successful re-intervention with metal stent trimming using argon plasma coagulation after endoscopic ultrasound-guided hepaticogastrostomy

Recently, endoscopic ultrasound (EUS)-guided biliary drainage has been introduced as an alternative method after failed endoscopic biliary drainage, particularly in patients with a pre-existing duodenal obstruction [1–3]. A longer self-expandable metal stent (SEMS) is usually used for EUS-guided hepaticogastrostomy (EUS-HGS) to prevent stent migration. However, re-intervention after EUS-HGS is challenging because of the protrusion of the SEMS into the stomach. Metal stent trimming using argon plasma coagulation (APC) has been reported to be a useful option for stent-related complications such as dislocation [4,5]. We report a case in which successful re-intervention after EUS-HGS was made possible by metal stent trimming using APC.

A nonagenarian woman with advanced ampullary cancer was admitted to our center. She had a history of endoscopic transpapillary bile duct stenting and duodenal stenting covering the papilla, followed by EUS-HGS with an 8-mm diameter, 12-cm long, silicone-covered nitinol braided stent, with a 1-cm uncovered portion at the proximal end (Niti-S biliary S-type; Taewoong Medical, Seoul, South Korea).

The patient developed recurrent cholangitis caused by sludge formation 3 months after HGS. As she showed a good performance status, we attempted therapeutic endoscopic intervention via the HGS site; however, intervention was difficult be-

![Protrusion into the stomach of the long self-expandable metal stent (SEMS) used for endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS): a on computed tomography (CT) scan; b on endoscopy.](image1)

![Views during endoscopy showing: a the self-expandable metal stent (SEMS) being trimmed with argon plasma coagulation (APC); b the shortened SEMS in situ; c the fragment of SEMS, which was subsequently removed with grasping forceps; d the sludge being removed with a retrieval balloon after successful bile duct cannulation.](image2)
cause of the protrusion of the long SEMS (Fig. 1). Therefore, stent trimming was performed with APC using an electrosurgical generator (ICC200; ERBE Elektromedizin, Tübingen, Germany) (Fig. 2a, b; Video 1). Subsequently, the fragment of SEMS was removed using grasping forceps through the scope channel (Fig. 2c). Successful bile duct cannulation was achieved using a standard endoscopic retrograde cholangiopancreatography (ERCP) catheter and a 0.025-inch guidewire. The sludge in the bile duct was confirmed on a cholangiogram and was removed with a retrieval balloon catheter (Fig. 2d; Video 2). Finally, a 5-Fr straight nasobiliary drainage tube was placed. The procedure was completed without any adverse events. Metal stent trimming using APC may be an effective option for re-intervention after EUS-HGS.

Endoscopy_UCTN_Code_TTT_1AR_2AZ

Competing interests: None

Kei Yane, Akio Katanuma, Hiroyuki Maguchi, Kuniyuki Takahashi, Manabu Osanai, Toshifumi Kin, Satoshi Ikarashi, Ryuki Minami, Manabu Sen-yo, Itsuki Sano, Hajime Yamazaki
Center for Gastroenterology, Teine-Keijinkai Hospital, Sapporo, Japan

References

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1377388
Endoscopy 2014; 46: E391–E392
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
Kei Yane, MD
Center for Gastroenterology
Teine-Keijinkai Hospital
1-jo 12-chome, Maeda, Teine-ku Sapporo 006-8555
Japan
Fax: +81-11-6852967
k.yane3@gmail.com

Video 1
Trimming of the protruding long self-expandable metal stent (SEMS) was performed using argon plasma coagulation (APC).

Video 2
Successful bile duct cannulation was achieved using a standard endoscopic retrograde cholangiopancreatography (ERCP) catheter and a 0.025-inch guidewire. The sludge was removed with a retrieval balloon.