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-

Fig. 1 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.

Fig. 2 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.
cause of the protrusion of the long SEMS (Video 1). Therefore, stent trimming was performed with APC using an electrosurgical generator (ICC200; ERBE Elektromedizin, Tübingen, Germany) (Fig. 1). Subsequently, the fragment of SEMS was removed using grasping forceps through the scope channel (Video 2). 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.

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.

Competing interests: None

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