Pericarditis: a rare complication of fully covered self-expandable metallic stent in postoperative benign anastomotic stricture

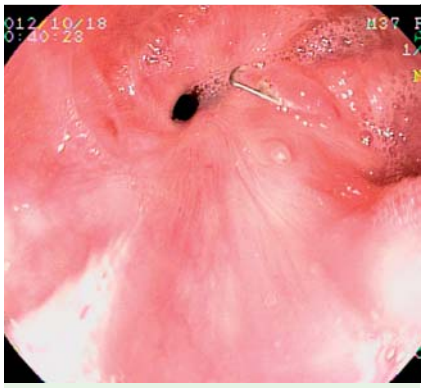

Fig. 1 Endoscopic view showing a marked stricture at the anastomotic site of esophagojejunostomy.

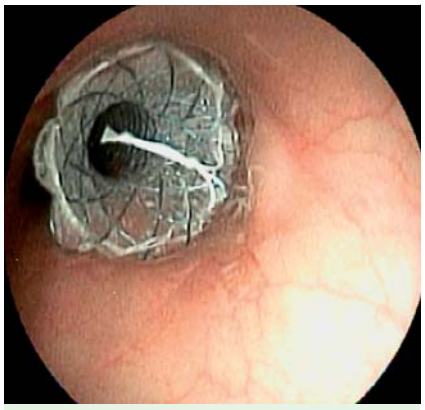

Fig. 2 Endoscopic view showing a fully covered, self-expandable, metallic stent placed at the anastomotic site of esophagojejunostomy.

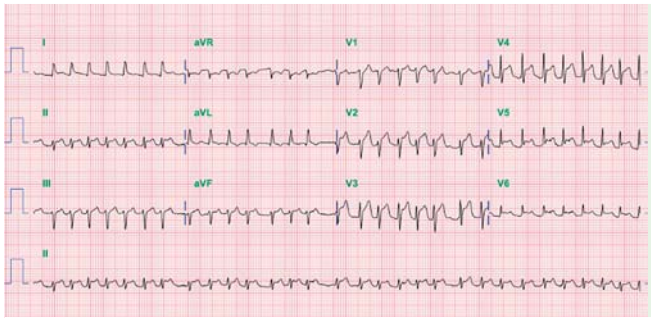

Fig. 3 Complete electrocardiography showed ST elevation in multiple leads.

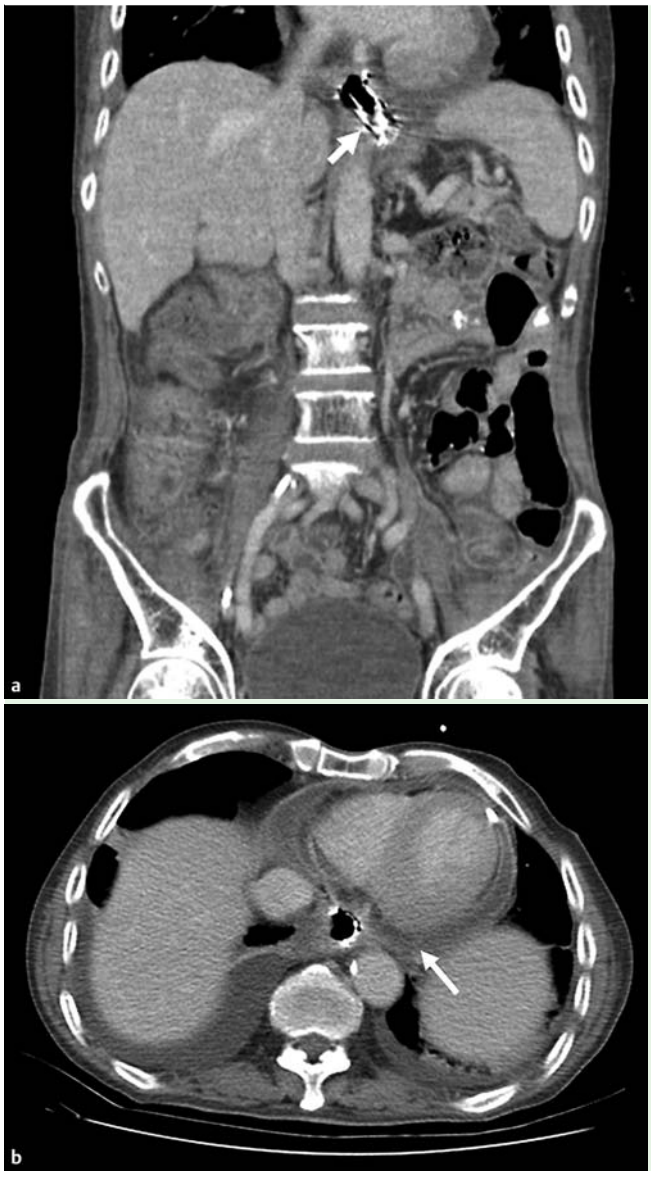

Fig. 4 Abdominal computed tomography. **a** Coronal section showing a 3-cm, self-expandable, metallic stent (SEMS; short arrow) at the anastomotic site of esophagojejunostomy. **b** Transverse section showing moderate pericardial effusion (long arrow). Note the adjacent proximal end of the SEMS in the esophagus.

Benign esophageal strictures are traditionally treated by endoscopic dilation with bougies or balloons [1,2]. Fully covered, self-expandable, metallic stents (SEMS) have been used in the treatment of benign esophageal disease, with the benefits of removability and low incidence of tissue hyperplasia [3]. However, significant complications, such as stent migration, recurrent stricture, or erosions into vital structures may occur [4,5]. We report on a novel case of pericarditis in a patient with recurrent postoperative benign anastomotic stricture, which was managed by placement of a fully covered SEMS.

A 71-year-old man presented at the emergency department with dyspnea and acute chest pain 3 months after endoscopic placement of a fully covered SEMS. He had undergone total gastrectomy with esophagojejunostomy 2 years earlier for gastric cancer. Upper endoscopy 6 months before the current admission showed a marked stricture at the anastomotic site of esophagojejunostomy (▶ **Fig. 1**). Recur-

rent strictures occurred even with repeated endoscopic dilation with bougie during the subsequent 3 months. A fully covered SEMS (Niti-S Comvi stent; Taewoong Medical, Seoul, Korea), 1 cm in diameter and 3 cm in length, was placed for the management of the recurrent benign anastomotic stricture (**Fig. 2**). He presented at the emergency department 3 months later with chest pain and dyspnea.

Complete electrocardiography (ECG) showed ST elevation in multiple leads (**Fig. 3**). Coronary angiography revealed no significant findings for coronary artery disease. Abdominal computed tomography with enhancement revealed a moderate amount of pericardial effusion (**Fig. 4a, b**). Emergency pericardiocentesis was performed due to a clinical diagnosis of pericarditis.

Culture of the pericardial effusion yielded positive result for *Staphylococcus aureus*. The fully covered SEMS was then removed endoscopically and pericarditis improved with antibiotic use for 21 days. Complete ECG at follow-up showed recovery to a normal sinus rhythm.

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Competing interests: None

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Bibliography

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