A 75-year-old woman was admitted for the extraction of an esophageal fully covered metal stent (upper esophageal sphincter stent [80 × 20 mm]; Leufen Medical, Berlin, Germany). The stent had been implanted 5 weeks earlier to treat an esophageal perforation sustained during bougienage of a benign proximal esophageal stenosis. The location of the stent was distal to the stricture, so that only a transnasal endoscope (EG-530NW [5.1-mm outer diameter and 2.0-mm working channel]; Fujifilm Europe, Düsseldorf, Germany) could be passed. Only a small biopsy forceps (FB-21K-1; Olympus, Tokyo, Japan) was available for stent manipulation. The upper retrieval loop of the stent was grasped with the forceps, but the loop was destroyed while traction was applied to remove the stent.

Using a biopsy forceps, we carried a 0.035-in guidewire (Jagwire; Boston Scientific, Natick, Massachusetts, USA) into the esophagus parallel to the endoscope. The guidewire was pushed through the distal retrieval loop (Fig. 1a, b) and then grasped with the forceps on the other side of the loop (Fig. 2). Subsequently, the guidewire was pulled out through the patient’s mouth, forming a loop (Fig. 3). With traction applied to the guidewire loop, the stent was now removed from the esophagus by inversion (“peeled away”) (Fig. 4, Video 1).

Several techniques have been described as alternatives to stent removal with a proximal retrieval loop. Retrieval of a stent from the stomach with a polypectomy snare (lasso technique) is used mostly when a stent has migrated, and in our case, it would have been necessary to use traction first to move the stent into the stomach [1]. Inversion of the stent, as in our case, reduces the shearing forces on the surrounding esophageal tissue and has been described previously [2, 3].
To the best of our knowledge, this is the first reported case of the use of a guidewire to extract an esophageal fully covered metal stent as a rescue procedure after damage of the proximal retrieval loop in the setting of a proximal esophageal stenosis.

Competing interests: None

References

Jochen Weigt1, Neven Barsic2, Peter Malfertheiner1
1 Department of Gastroenterology, Hepatology, and Infectious Diseases, Otto-von-Guericke University, Magdeburg, Germany
2 Department of Gastroenterology and Hepatology, Sestre Milosrdnice University Hospital Center, University of Zagreb School of Medicine, Zagreb, Croatia

Fig. 3 The guidewire now forms a loop at the distal part of the stent, with both ends outside.

Fig. 4 With traction applied to the guidewire loop, the stent is removed from the esophagus by inversion (“peeled away”).

Bibliography
DOI http://dx.doi.org/ 10.1055/s-0034-1391356
Endoscopy 2015; 47: E129–E130
© Georg Thieme Verlag KG Stuttgart · New York ISSN 0013-726X

Corresponding author
Jochen Weigt, MD
Department of Gastroenterology, Hepatology, and Infectious Diseases
Otto-von-Guericke University
Universitätsplatz 2
39106 Magdeburg
Germany
Jochen.Weigt@med.ovgu.de