Stent migration into the peritoneal cavity following endoscopic ultrasound-guided hepaticogastrostomy

It is not always possible to perform endoscopic retrograde cholangiopancreatography, and endoscopic ultrasound-guided biliary drainage (EUS-BD) has been performed as an alternative to percutaneous or surgical approaches [1,2]. The 2008 EUS Working Group summarized the indications, techniques, and complications of EUS-guided hepaticogastrostomy (EUS-HGS) [3]. The rate of complications reported for EUS-BD performed by experts was 0%–30%. Major complications included stent migration, bile leakage, peritonitis, and cholangitis [3,4].

A 58-year-old man had unresectable pancreatic cancer. He had undergone EUS-guided choledochoduodenostomy and duodenal stent placement. Because obstructive jaundice was recurrent, EUS-HGS was performed with the patient’s consent. A linear EUS scope was used. The intrabiliary bile duct (B3) was punctured with a 19-gauge needle (SonoTip Pro Control 19G; Medi-Globe GmbH, Rosenheim, Germany; Medico’s Hirata Inc., Osaka, Japan). After contrast medium was injected, a 0.025-inch guide wire (VisiGlide; Olympus Medical Systems, Tokyo, Japan) was introduced through the needle and placed into the common bile duct. The fistula was dilated using a 9-Fr tapered biliary dilation catheter (Soehendra biliary dilation catheter; Cook Endoscopy; Bloomington, Indiana, USA). Finally, a fully covered metallic stent (8 mm×8 cm Wallflex; Microvasive Endoscopy, Boston Scientific, Natick, Massachusetts, USA) was placed. Inward stent migration occurred immediately (Fig. 1), which would be a fatal complication [4,5].

Fortunately, the man was able to resume oral intake after surgery; however, 44 days later, he died as a result of peritonitis carcinoma.

Anatomically, the stomach is not directly attached to the liver, and during EUS-HGS there is no space between these organs when the echoendoscope is pressed against the stomach wall. Pulling back the echoendoscope for stent placement creates space between the liver and stomach wall. Given this complication, stents with lengths of 10 or 12 cm should be used to avoid inward stent migration.

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Nozomi Okuno, Kazuo Hara, Nobumasa Mizuno, Susumu Hijioka, Hiroshi Imaoka, Kenji Yamao
Department of Gastroenterology, Aichi Cancer Center Hospital, Nagoya, Japan

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Corresponding author
Kazuo Hara, MD
Departments of Gastroenterology and Endoscopy
Aichi Cancer Center Hospital
1-1 Kanokoden
Chikusa-Ku
Nagoya 464-8681
Japan
Fax: +81-52-7635233
khara@aichi-cc.jp

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