Spontaneous tearing of a duodenal metallic stent: a rare adverse event

Duodenal metallic stent placement is one of the options for the palliative treatment of malignant duodenal obstruction [1]. However, this palliative procedure is associated with several adverse events; stent migration, bleeding, and perforation have been reported [2–5]. If the site of obstruction is in the duodenal bulb, the duodenal stent should be placed from the stomach to the duodenum across the pylorus. At this site, stent injury may be caused by pyloric spasm. Herein, we describe a rare adverse event – duodenal metallic stent tearing due to pyloric spasm – and our successful re-intervention.

A 67-year-old man was admitted to our hospital because of nausea and vomiting. He had undergone chemotherapy for bladder cancer. In addition, an uncovered duodenal metallic stent (Niti-S, 22 mm × 12 cm; Taewoong Medical, Seoul, Korea) had been placed from the stomach to the second part of the duodenum because of duodenal bulb stenosis resulting from malignant peritonitis 2 months earlier. Computed tomographic and fluoroscopic imaging showed tearing of the duodenal stent (Figs. 1, 2). Therefore, we tried to re-intervene. A gastroduodenoscope was inserted into the stomach, and the uncovered duodenal stent is seen to be torn. The duodenal stent is trimmed. Then, the stent is grasped and successfully removed.

Duodenal metallic stent placement is one of the options for the palliative treatment of malignant duodenal obstruction [1]. However, this palliative procedure is associated with several adverse events; stent migration, bleeding, and perforation have been reported [2–5]. If the site of obstruction is in the duodenal bulb, the duodenal stent should be placed from the stomach to the duodenum across the pylorus. At this site, stent injury may be caused by pyloric spasm. Herein, we describe a rare adverse event – duodenal metallic stent tearing due to pyloric spasm – and our successful re-intervention.

A 67-year-old man was admitted to our hospital because of nausea and vomiting. He had undergone chemotherapy for bladder cancer. In addition, an uncovered duodenal metallic stent (Niti-S, 22 mm × 12 cm; Taewoong Medical, Seoul, Korea) had been placed from the stomach to the second part of the duodenum because of duodenal bulb stenosis resulting from malignant peritonitis 2 months earlier. Computed tomographic and fluoroscopic imaging showed tearing of the duodenal stent (Figs. 1, 2). Therefore, we tried to re-intervene. A gastroduodenoscope was inserted into the stomach, and the uncovered duodenal stent is seen to be torn. The duodenal stent is trimmed. Then, the stent is grasped and successfully removed.

A 67-year-old man was admitted to our hospital because of nausea and vomiting. He had undergone chemotherapy for bladder cancer. In addition, an uncovered duodenal metallic stent (Niti-S, 22 mm × 12 cm; Taewoong Medical, Seoul, Korea) had been placed from the stomach to the second part of the duodenum because of duodenal bulb stenosis resulting from malignant peritonitis 2 months earlier. Computed tomographic and fluoroscopic imaging showed tearing of the duodenal stent (Figs. 1, 2). Therefore, we tried to re-intervene. A gastroduodenoscope was inserted into the stomach, and the uncovered duodenal stent is seen to be torn. The duodenal stent is trimmed. Then, the stent is grasped and successfully removed.
stent (ComVi, 20 mm ×10 cm; TaeWoong Medical) (Fig. 6). After this procedure, during the 2 months until the patient’s death, the vomiting caused by both tumor growth and stent tearing did not recur. Stent tearing due to pyloric spasm is a rare adverse event. To prevent it, when a duodenal stent is placed from the stomach to the duodenum, it may be preferable to use a fully covered duodenal metallic stent.

Endoscopy_UCTN_Code_CPL_1AH_2AD

Competing interests: None

Takeshi Ogura, Wataru Takagi, Saori Onda, Daisuke Masuda, Toshihisa Takeuchi, Shinya Fukunishi, Kazuhide Higuchi
2nd Department of Internal Medicine, Osaka Medical College, Osaka, Japan

References

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1393139
Endoscopy 2015; 47: E495–E496
© Georg Thieme Verlag KG Stuttgart · New York ISSN 0013-726X

Corresponding author
Takeshi Ogura, PhD, MD
2nd Department of Internal Medicine
Osaka Medical College
2-7 Daigakuchou
Takatsukishi
Osaka 569-8686
Japan
Fax: +81-52-763-5233
oguratakeshi0411@yahoo.co.jp