Small-bowel obstruction due to a migrated cystogastric endoprosthesis: report of a case

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References


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Figure 1 A scout computed tomogram shows the progression of the migrated double-pigtail endoprosthesis into the right lower quadrant of the abdomen.

Endoscopic ultrasound (EUS)-guided cystogastrostomy has been reported to be a safe and efficient method for drainage of pancreatic pseudocysts [1–3]. More common complications include hemorrhage, perforation, and cyst infection due to stent clogging [3, 4]. We report here on a case of small-bowel obstruction caused by migration of a cystogastric endoprosthesis, which was successfully managed without surgery.

A 49-year-old patient was admitted to our institution because of fever and epigastric pain, associated with hyperleukocytosis. His medical history included hypertension, testicular cancer treated by orchiectomy plus chemoradiotherapy, and alcohol-induced chronic pancreatitis complicated by pancreatic and biliary duct strictures, which had required endoscopic stenting. Computed tomography (CT) revealed a 6-cm collection posterior to the antrum, and EUS-guided cystogastrostomy was carried out in order to place a 7-Fr nasocystic drain and, after 1 week, a 10-Fr, 3-cm double-pigtail stent. The patient made an uneventful postoperative recovery and was discharged home 2 days after the procedure. However, 3 weeks later, the patient presented again with intense abdominal pain and nausea. On examination, the abdomen was found to be distended but generally tender, with no evidence of peritonism. CT scanning showed that the prosthesis was impacted in the small bowel, with the intestine above dilated (Figure 1, 2). There was no residual fluid collection. The situation resolved with conservative measures (intravenous erythromycin, analgesics, and nasogastric aspiration), and the patient was discharged home after evacuation of the prosthesis.

Gérolami et al. described a similar case of a patient with pancreatic pseudocyst who presented with intestinal obstruction due to migration of a previously placed cystogastric endoprosthesis and was successfully treated conservatively [5]. In conclusion, bowel obstruction due to the migration of a cystogastric stent is exceedingly rare and can be safely managed without surgery in the absence of any signs of peritonitis. Stent removal is advised after complete resolution of the pseudocyst.

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