Dear Editor,

We present the case of a 54-year-old woman with surgical gastrojejunostomotic stenosis resolved by the placement of a coated yo-yo type self-expanding metal stent approved for the drainage of pancreatic pseudo-cysts.

The patient had undergone emergency laparoscopic surgery for digestive obstruction due to duodenal compression caused by the retroperitoneal metastatic adenopathies of disseminated breast cancer.

One month after surgery the patient presented oral intolerance with gastric retention, and digestive endoscopy showed almost complete stenosis of the surgical anastomosis, without data showing tumoral infiltration (Fig. 1A).

Under fluoroscopic and endoscopic monitoring a 16x30 mm self-expanding fully covered Link stent (Niti-S, Taewoong) was put into place, reopening the anastomosis and giving access to the intestinal loop (Fig. 1B).

After 24 hours an oral diet was recommenced, and two months after the implant the efficacy and non-migration of the stent was confirmed (Fig. 1C). The patient died five months after the procedure due to her underlying disease, while digestive transit was maintained at all times.

Discussion

Derivative surgery (gastrojejunostomy) has been the treatment of choice for malignant gastric outlet obstruction before the development of enteral stents (1-3). Surgical by-pass is not risk free, and stenosis of the anastomosis may occur in 3-13 % of cases after gastric surgery. This complication can be treated endoscopically by means of dilation and/or the insertion of a self-expanding metal stent (4,5).

There are endoscopically guided systems for enteral anastomosis to drain benign biliopancreatic pathology, based on the implantation of specific coated metal stents (6). As this type of stent has bilateral flaps around each end and a short body, they are able to make close contact with structural walls, reducing the risk of migration and making them ideal for the creation and maintenance of enteral bypasses. The said fixing systems makes it possible to reduce the size of the stent which is ideal for the resolution of short anastomotic stenosis in which the choice of a conventional longer stent would give rise to greater anatomic distortion and tension along the walls of the digestive tract, with the risk of decubitus and complications over the mid-term. Likewise, its coating aids subsequent removal and reduces aggression on the surface mucosa.

In the case described, as it involved stenosis of a very short surgical anastomosis, similar to the path sought in echoendoscopic procedures, the yo-yo type stent seemed to be the most suitable one from an anatomical point of view, with low risk of migration and the possibility of removal in the future if it became ineffective.

As this procedure was undertaken for palliative reasons, the possibility of removal was not evaluated, and in out-patient follow-up a complete clinical response was observed. As far as we know, no similar cases have been reported, and we believe that this technique could be used more widely to rechannel surgical anastomosis such as the case described here.

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References


Fig. 1. A. Stenosis of surgical gastrointestinal anastomosis. B. Rechanneling with a coated metal “Link” stent, showing jejunal loop. C. Radiological visualisation 2 months after implant, confirming the persistence and functionality of the stent (detail of the stent, with marking clip affixed).