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Gastroenterology

A RARE CASE OF RETAINED ESOPHAGEAL STENT - CASE REPORT

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ABSTRACT Due to the latest advancements in the manufacturing of Self-Expanding Metallic Stents (SEMS) and its various types available, Endoscopists have extended their use to treat various clinical problems such as Benign/Malignant strictures, Anastamotic leaks after surgery, Fistulas. Benign strictures are normally treated by Endoscopic dilatation program and Acid suppression therapy. But recently SEMS are also been used for treating the same. Complications that follow this procedure includes Dislodgement, Obstruction, Migration and Impaction. The treating Endoscopist should be aware of these complications and should try to avoid it. We present a case of young male who presented with Dysphagia following Endoscopic stenting for benign Esophageal stricture. Timely removal of the stent was not done for the patient and he later presented to us with Stent being migrated and impacted for which he required surgical intervention.

KEYWORDS : Dysphagia, Stent migration, Corrosive ingestion, Esophageal stricture

CASE REPORT :

A 35 yr old male presented to us with Dysphagia for 1 yr duration which was initially for solids and later on for liquids. Patient had History of Corrosive ingestion 1 ½ yrs back, following which he developed Esophageal stricture. Initially he was treated conservatively and later Stenting was done for the same using Self Expanding Metallic stent. Patient was symptomatically better after the procedure. But patient was not compliant and did not turn up for timely removal of stent and subsequently patient developed dysphagia and he came to our hospital for further management.Patient was evaluated by Endoscopy which revealed a stent at middle 3rd of esophagus which was completely impacted under the muscular layer of esophagus and the lumen was completely occluded by ingrowth of granulation tissue. CECT Thorax was done, which showed the Distal portion of stent in the proximal part of stomach.Initially Endoscopic removal was attempted, but since the stent was completely embedded under the esophageal muscular layer,it was abandoned.

So patient was planned for Exploratory Laparotomy and Trans –Gastric removal of the stent was attempted, but stent could not be removed, hence Right Thoracotomy was done. Stricturous,diseased esophagus along with the stent was carefully dissected and mobilized all around form the adjacent vital structures. And this portion of Esophagus with the stent and proximal portion of stomach was resected and Stomach was pulled up into the thorax and end to end Esophago-Gastric anastamosis was done using 3-0 Vicryl.ICD kept in situ. Post-op period was uneventful.Patient was started on Oral feeds on POD-7 after doing Oral Gastrograffin study which revealed no evidence of leak. Pt was discharged on POD-10. Patient came for follow up after 3 months and was doing well.

DISCUSSION :

Benign Esophageal strictures are routinely treated by endoscopic Dilatation program and Acid suppressive therapy. Surgery remains the mainstay of treatment in Refractory cases. But due to recent advancements in Stents ,experienced Endoscopists are also attemptimg to treat Benign strictures by Stenting. As with any Surgical procedure/dilatation program, stenting has its own complications .This includes Obstruction, migration, impaction, erosion into major adjacent structures. Factors predisposing to these complications include, Inexperience of Endoscopist, Inapproprite usage of stent, Inadequate patient education and delay in removal of stent.

Stent migration is common with usage of Covered Stents. Impaction is common with Uncovered Stents. The ideal stent stent should be Easily retrievable/repositioned, Technically easy to place, Designed to have small caliber delivering device with minimal shortening on usage and should have low migration rates, Insertion and removal should be assosciated with minimal complications. If such complications are encountered patient must be evaluated initially with CXR,UGI scopy, CECT if needed and then it can be tackled by both Endoscopic and surgical interventions.

Endoscopic approach include placement of stent within a stent or usage of diathermy to release the impaction and removal of stent. Surgical approaches include Laparoscopy, Laparotomy, Thoracotomy for removal of stent with / without resection of esophagus/stomach.

CONCLUSION :

SEMS are best avoided in benign Esophageal strictures, if deployed it should be a covered and removable stent. And it should be removed within 3 months / it can lead on to such life-threatening major complications leading to increased morbidity for the patient.

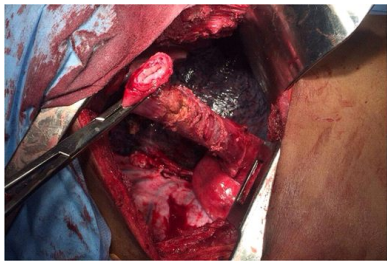

Figure:1 Intraoperative stent with Diseased Esophagus

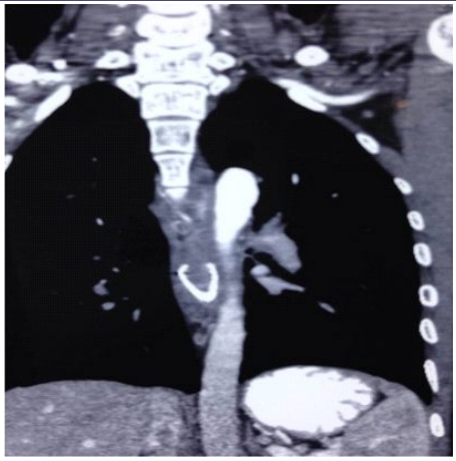

Figure:2 Showing Retained Esophageal Stent

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