A. Esophageal Stenting and related topics


Removable Self-Expanding Plastic Esophageal Stent as a Continuous, Non-Permanent Dilator in Treating Refractory Benign Esophageal Strictures: A Prospective Two-Center Study

BACKGROUND: Refractory benign esophageal strictures (RBES) are difficult to treat requiring frequent dilatations or surgery. Conceptually, while maintaining luminal patency, if a dilator is kept in place continuously for several weeks, the benefits may be longer lasting. An expandable esophageal stent will be ideal in achieving the above. Preliminary results on using a removable self-expanding plastic esophageal stent, Polyflex stent (PS), for treating RBES have been mixed.

AIM: To evaluate the efficacy of PS in the treatment of RBES.

METHODS: Forty patients with RBES [mean age 60 ± 15 SD yrs, female 14, male 26, Anastomotic 12 (fistula 4), Corrosive 8, Radiation 7, Pill induced 4, Post trauma 3 (fistula 3), Peptic 2, Others 4 (fistula 1)] were prospectively studied. Continuous non-permanent dilation was performed by placing a PS and removing it after 4 wk. The patients were then followed at regular intervals. Pre-insertion baseline data and post-removal information on dysphagia status, complications, and change in outcome were prospectively collected.

RESULTS: The technical success in stent placement and stent removal were 95% and 94%, respectively. Mean post-stent dysphagia score was 0.6 ± 0.7 SD, which was significantly better than pre-stent scores (3.0 ± 0.8 SD; P < 0.001). At median follow-up of 53 wk (range 11–156), only 40% (intention to treat 30%) patients were dysphagia-free. However, the overall change in outcome from baseline options (ongoing dilatations, or surgery) was 66% (dysphagia-free 12, did not want removal 2, did not remove 1, preferred long-term stenting 10). The stent was successful in closing the fistula in five of eight (63%) patients. Complications observed were migration eight (22%), severe chest pain four (11%), bleeding three (8%), perforation two (5.5%), GE reflux two (5.5%), impaction two (5.5%), and new fistula one (2.7%). There was one mortality from massive bleeding.

CONCLUSIONS: It was feasible to deploy and remove PS stents in the majority of patients with RBES. Some patients achieved long-term relief without further re-interventions while several others re-strictured and preferred long-term stenting over repeated dilations or surgery. The procedure carries significant risks and hence should only be considered in carefully selected patients.

2 AMJG 2008, 103, 12:2995 – 2996

EDITORIAL

Refractory Benign Esophageal Strictures: Extending the Role of Expandable Stents

It is challenging to manage benign refractory esophageal strictures. We have now moved on from instant dilators to prolonged gradual dilatations using expandable stents that can be removed or biodegradable after a period of time left in situ. Recent published experience and the present study by Dua et al. have demonstrated the feasibility of this technique. However, not all strictures are the same and several issues need to be addressed including stent migration, stent duration, and the sub-group of patients who will benefit most.

B. Biliary and pancreatic stenting, and related topics
LETTERS TO THE EDITOR

Stent-In-Stent Insertion Using Argon Plasma Coagulation for the Cannulation of Multiple Malfunctioning Biliary Noncovered Self-Expandable Metal Stents

The article was published without an abstract.

GIE 2008, 68, 6:1076-1080

The safety and effectiveness of endoscopic biliary decompression by plastic stent placement in acute suppurative cholangitis compared with nasobiliary drainage

Background
Endoscopic retrograde biliary drainage (ERBD) by using a plastic stent is suggested to be as effective as endoscopic nasobiliary drainage (ENBD) for temporary biliary drainage in acute suppurative cholangitis (ASC). However, there are few studies that compared ERBD and ENBD in ASC.

Objectives
We compared the safety and efficacy of ERBD and ENBD for temporary biliary drainage in patients with ASC.

Design
A case series.

Setting
A tertiary-referral center.

Patients and Interventions
Eighty patients with ASC underwent endoscopic biliary drainage with ENBD (n = 41) and ERBD (n = 39).

Main Outcome Measurement
Clinical outcomes, including complications related to ERCP and complications related to the type of the indwelling catheter.

Results
Endoscopic biliary drainage was successfully achieved in all patients (100%). There were no significant differences in the demographic data between the 2 groups. There were no differences in the improvement of clinical and laboratory parameters between the 2 groups. Overall ERCP-related complication rates in the ENBD and ERBD groups were 31.7% and 38.5%, respectively (P = .527). Hyperamylasemia occurred in 18 patients, 12.2% in the ENBD group (5/41) and 33.3% in the ERBD group (13/39) (P = .024). Without endoscopic sphincterotomy (EST), there was no statistically significant difference in the incidence of hyperamylasemia between the 2 groups. However, with an EST, hyperamylasemia was more frequent in the ERBD group (12/28 [42.9%]) than in the ENBD group (3/27 [11.1%]) (P = .008).

Limitation
A single-center experience.

Conclusions
Endoscopic biliary decompression, whether by ERBD or ENBD, is an effective treatment for patients with ASC. However, more frequent hyperamylasemia with ERBD and EST deserves further evaluation.
C. Colorectal stenting and related topics

Fluoroscopically Guided Placement of Self-Expandable Metallic Stents and Stent-Grafts in the Treatment of Acute Malignant Colorectal Obstruction

Purpose
To evaluate the technical feasibility and clinical effectiveness of fluoroscopically guided placement of self-expandable metallic stents and stent-grafts for acute malignant colorectal obstruction.

Materials and Methods
Radiologic images and clinical reports of 42 patients (22 men, 20 women; age range, 28–93 years; median age, 65.5 years) who underwent fluoroscopically guided colorectal stent insertion without endoscopic assistance for acute malignant obstruction were reviewed retrospectively. Eighteen patients received bare stents as a bridge to surgery. Twenty-four patients received 27 insertions of either a bare stent (n = 15) or a stent-graft (n = 12) for palliation. The obstruction was located in the rectum (n = 8), sigmoid (n = 17), descending colon (n = 8), splenic flexure (n = 3), and transverse colon (n = 6).

Results
Clinical success, defined as more than 50% dilatation of the stent with subsequent symptomatic improvement, was achieved in 41 of the 42 patients (98%). No major procedure-related complications occurred. Minor complications occurred in eight of the 45 procedures (18%). No perioperative mortalities occurred within 1 month after surgery. In the palliative group, the median stent patency was 62 days (range, 0–1,014 days). There was no statistically significant difference in stent patency between the bare stents (range, 0–855 days; median, 68 days) and stent-grafts (range, 1–1,014 days; median, 81 days).

Conclusions
Fluoroscopically guided placement of self-expandable metallic stents and stent-grafts for the relief of acute malignant colorectal obstruction was technically feasible without endoscopic assistance—even in lesions proximal to the splenic flexure and transverse colon—and clinically effective in both bridge to surgery and palliative management.

D. TIPS Stenting and related topics

Technical Challenges in TIPS Creation via the Right Subclavian Vein
This report describes a 64-year-old man with Laennec cirrhosis requiring a transjugular intrahepatic portosystemic shunt (TIPS) to alleviate ascites before surgical mesh repair of a large symptomatic umbilical hernia. During the procedure, both internal jugular veins and the right external jugular vein were found to be occluded. The right subclavian vein was accessed and a TIPS was successfully created. Some of the technical challenges encountered in performing the procedure from the right subclavian vein are described.

E. Endovascular peripheral stenting and related topics

Do patients with endovascular prostheses require prophylactic antibiotics before they undergo ERCP?
See enclosed full-text article which was published as free.
Response

See enclosed full-text article which was published as free.