

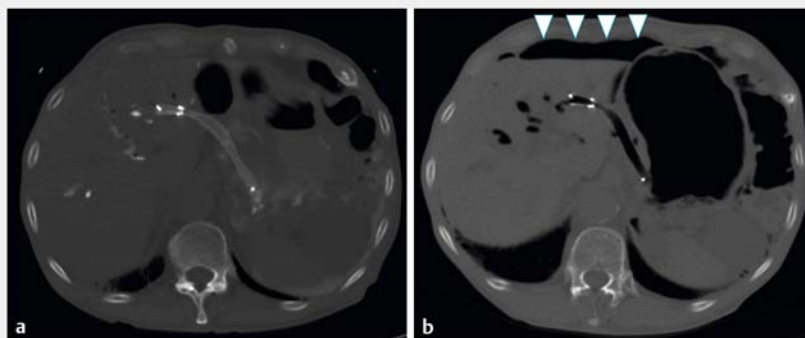
Title	Successful reintervention using dual-channel endoscope for perforation by partially migrated stent after endoscopic ultrasound-guided hepaticogastrostomy
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Description	

Successful reintervention using dual-channel endoscope for perforation by partially migrated stent after endoscopic ultrasound-guided hepaticogastrostomy

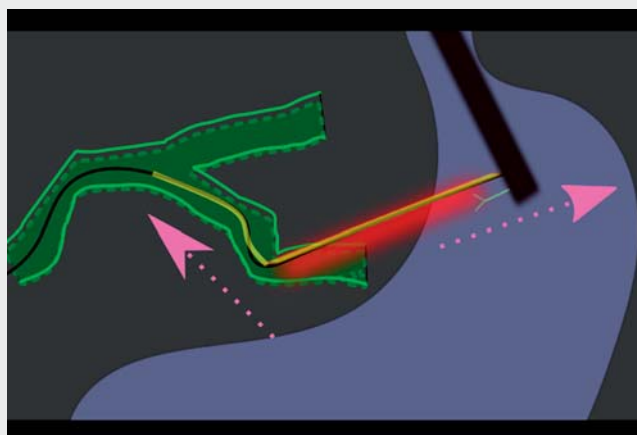
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Endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS) is the standard endoscopic procedure for biliary obstructions [1–2]. Although various complications such as migration, perforation, and abdominal peritonitis have been reported after EUS-HGS [3–5], the reintervention method for them has not been established. Herein, we present a case of successful reintervention for a migrated stent after EUS-HGS using a dual-channel endoscope and grasping forceps.

An 88-year-old man with pancreatic cancer underwent EUS-HGS for malignant biliary obstruction, and a partially covered self-expandable metallic stent (SEMS) was placed on the B3 branch. The patient had a high fever 2 days after EUS-HGS. Computed tomography (CT) revealed free air in the abdominal cavity (▶ **Fig. 1**), which was caused by the shifting of the uncovered part of the SEMS to the gastric side by respiratory fluctuation. A reintervention for additional stent placement was urgently performed. A dual-channel endoscope (GIF-2TQ260M; Olympus, Tokyo, Japan) was inserted into the EUS-HGS site. A guidewire was then advanced through the EUS-HGS stent into the right hepatic duct (▶ **Video 1**). However, the catheter could not advance through the B3 branch due to its strong bend. The EUS-HGS stent was too long, poorly anchored, and was difficult to align with the axis; therefore, it could not transmit force in the direction of the catheter (▶ **Fig. 2**). Grasping forceps inserted from the other channel grasped and pulled the stent (▶ **Fig. 3**), after which the catheter and stent delivery system advanced through the bend of the B3 branch by counter-traction (▶ **Fig. 4**). The fully covered SEMS (Boston Scientific, Marlborough, Massachusetts, USA) was then deployed through the stent to the proximal B3 branch (▶ **Fig. 5**). After 1 week, CT showed the disappearance of free air and the biliary metallic stent in



▶ **Fig. 1** Computed tomography images. **a** No free air in the abdominal cavity immediately after endoscopic ultrasound-guided hepaticojejunostomy (EUS-HGS). **b** The presence of free air 2 days after EUS-HGS.



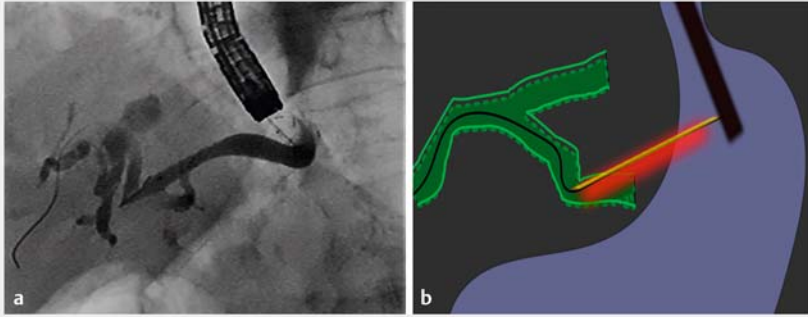
▶ **Video 1** As a reintervention for additional stent placement, a dual-channel endoscope and grasping forceps were used. Pulling the endoscopic ultrasound-guided hepaticogastrostomy stent by grasping the forceps, catheter, and stent delivery system enabled passage through the bend of the B3 branch by counter-traction.

the appropriate position. Stent placement using a dual-channel endoscope and grasping forceps may be considered a useful treatment for stent complications after EUS-HGS.

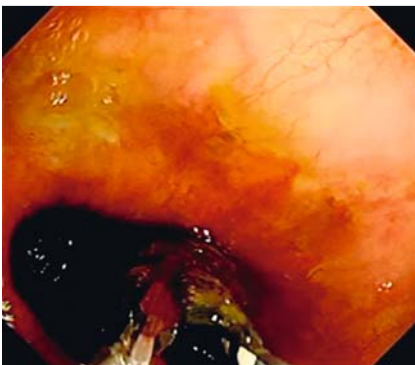
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Competing interests

The authors declare that they have no conflict of interest.



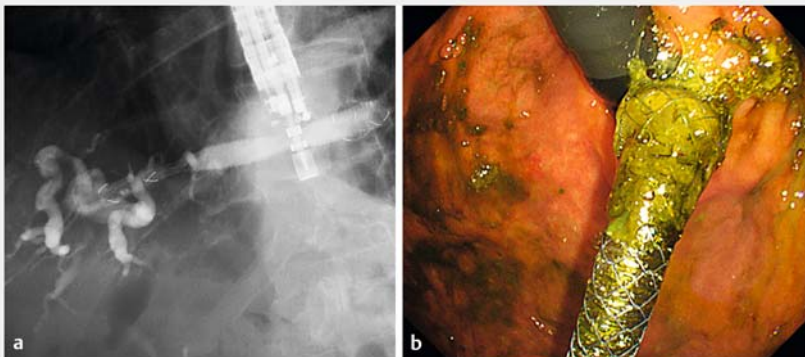
► **Fig. 2** Catheter could not advance through the strong bend of the B3 branch. **a** Fluoroscopic view. **b** Schema.



► **Fig. 3** Endoscopic view showing the stent grasped using grasping forceps inserted from the other forceps channel of the dual-channel endoscope.



► **Fig. 4** Fluoroscopic view showing the passage of the catheter by counter-traction through the strong bend of the B3 branch by pulling the grasped stent.



► **Fig. 5** **a** Fluoroscopic view showing the deployment of the additional biliary metallic stent beyond the bend of the B3 branch to the proximal site in a stent-in-stent manner. **b** Endoscopic view showing the additional biliary metallic stent.

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