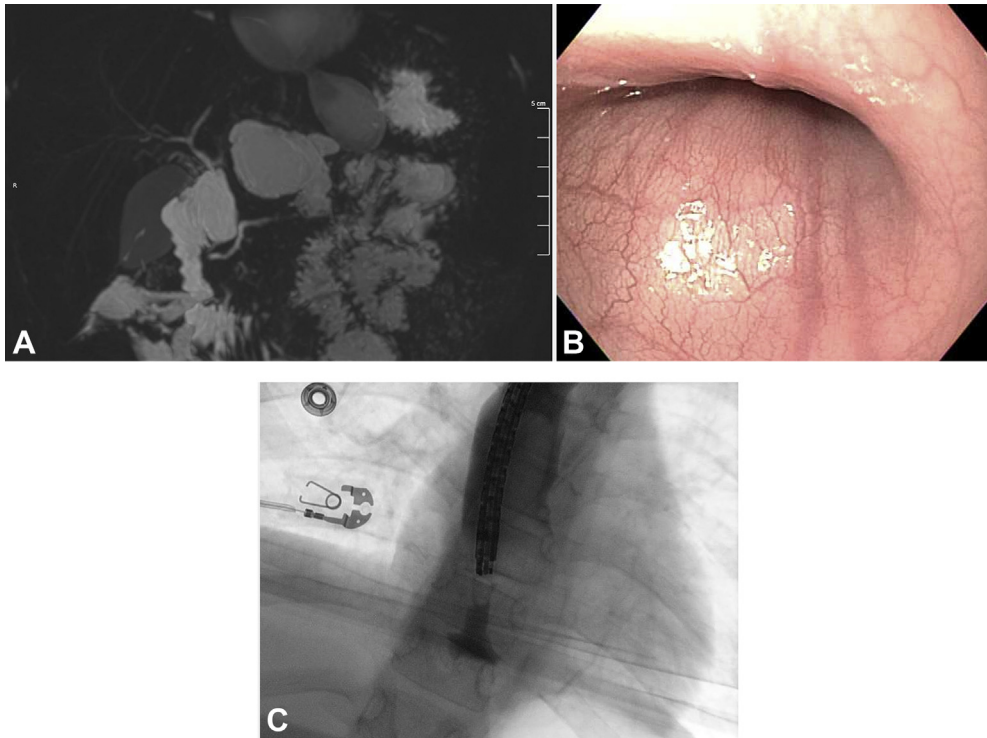




## EUS-guided cystesophagostomy using a lumen-apposing metal stent for drainage of a pancreatic fluid collection in a pediatric patient



**Figure 1.** **A**, MRCP view demonstrating a bilobed pancreatic fluid collection extending across the diaphragm and into the mediastinum. **B**, Notable extrinsic compression in the distal esophagus from the mediastinal fluid collection. **C**, Complete resolution of the mediastinal fluid collection after removal of the lumen-apposing metal stent.

An 8-year-old boy was referred because of abdominal pain, dysphagia, and failure to thrive (weight loss/poor growth). He had made multiple visits to the emergency department over a 5-year period for abdominal pain of unclear etiology. His abdominal pain was thought to be related to constipation, and he was treated accordingly. His amylase/lipase levels were previously elevated but were nondiagnostic for acute pancreatitis. The results of colonoscopy and upper endoscopy were negative for any obvious cause. Magnetic resonance enterography demonstrated a bilobed fluid collection superior to the pancreas with a 3-cm × 3.5-cm component near the gastric body in continuity with a 6.5-cm × 5-cm component in the mediastinum (Fig. 1A). This was thought to be a pancreatic fluid collection (PFC) after an undiagnosed bout of acute

pancreatitis. The PFC was consistent with a pseudocyst because minimal tissue necrosis was visualized. The patient subsequently received a diagnosis of hereditary chronic pancreatitis related to 2 mutations in the chymotrypsin C gene. We performed EUS-guided drainage of his PFC (Video 1, available online at [www.VideoGIE.org](http://www.VideoGIE.org)).

Routine upper endoscopy showed extrinsic compression of the distal esophagus (Fig. 1B). An oblique-viewing, linear-array echoendoscope was used, and the fluid collection from the esophagus and stomach was examined. Transesophageal EUS-guided drainage was indicated because the abdominal component of the fluid collection was inaccessible owing to the intervening vasculature. Under direct EUS visualization, transesophageal puncture was performed with a 19-gauge FNA needle. Murky, tan-colored

Written transcript of the video audio is available online at [www.VideoGIE.org](http://www.VideoGIE.org).

fluid was aspirated and sent for evaluation, the results of which were as follows: cytology, negative results; carcinoembryonic antigen, within normal limits; amylase, >7000 IU/L. A guidewire was coiled within the fluid collection, and a 4-mm biliary dilating balloon was used to dilate the tract. Ultimately, a 10-mm × 10-mm lumen-apposing metal stent (LAMS) was deployed to drain the collection. A10F × 4-cm double-pigtail plastic stent was placed within the LAMS. The patient was discharged with advice to advance gradually to a soft diet. All stents were removed 4 weeks later, and resolution of the PFC was demonstrated by cross-sectional imaging and injection of contrast material under fluoroscopy (Fig. 1C). The patient remains symptom free more than 1 month later.

## DISCLOSURE

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