

Simultaneous passage of ultra-slim colonoscope and colonic stent catheter across left-sided colonic stent for placement of a hepatic flexure stent for malignant large-bowel obstruction

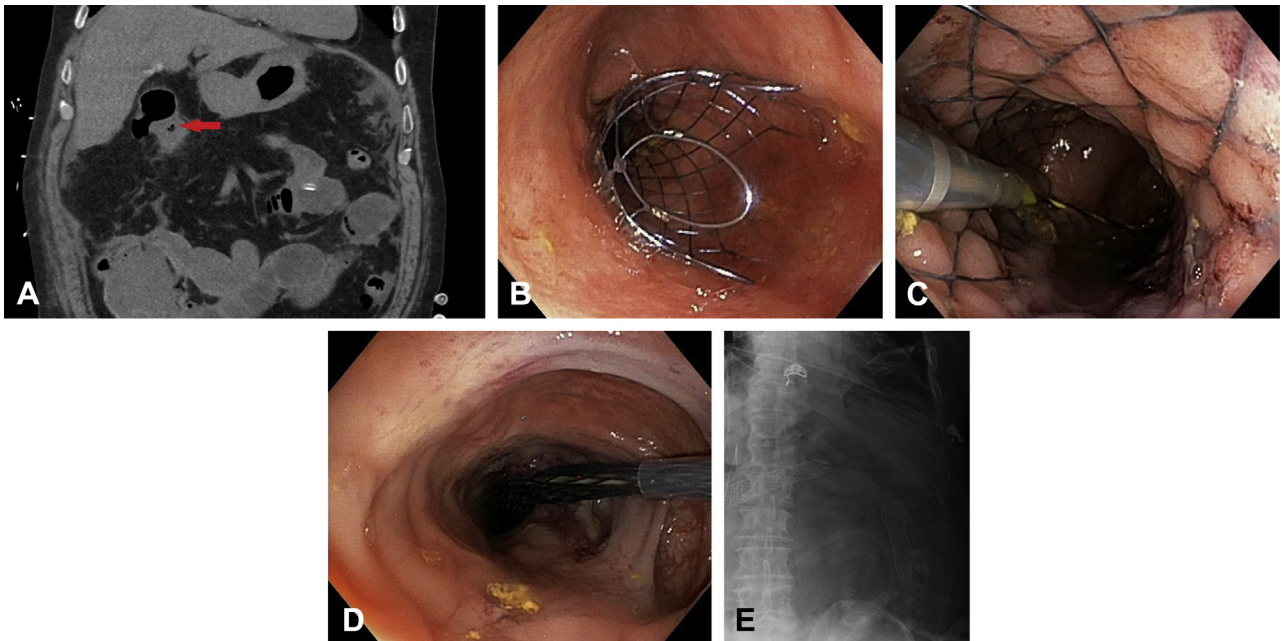


Figure 1. **A**, CT coronal view of abdomen and pelvis without contrast medium showing transition point (*arrow*) at the hepatic flexure concerning for large-bowel obstruction. **B**, Endoscopic view of descending colon stent placement. **C**, Endoscopic view of colonic stent catheter and ultra-slim colonoscope across the descending colon stent. **D**, Endoscopic view of stent deployment across hepatic flexure stricture. **E**, Abdominal radiographic view of the hepatic flexure and descending colon stents after the procedure.

A 74-year-old man with metastatic gastric cancer with carcinomatosis who was receiving palliative chemotherapy presented with nausea, vomiting, and abdominal distension. CT of the abdomen showed distended loops of the small bowel, cecum, and ascending colon with a transition point at the hepatic flexure that raised concern for large-bowel obstruction (Fig. 1A). A nonsurgical endoscopic approach was preferred by the patient after a discussion of management options.

Colonoscopy showed luminal narrowing in the descending colon, likely due to peritoneal carcinomatosis, which could not be traversed with a 39F adult colonoscope (CF-HQ190L, Olympus America, Center Valley, Penn). A 29F ultra-slim colonoscope (PCF-PH190L, Olympus America) was used to traverse the narrowing, and a second stricture was noted at the hepatic flexure. This area could not be

traversed with the ultra-slim colonoscope. Fluoroscopic imaging revealed narrowing of the hepatic flexure and dilated right side of the colon. Using an adult colonoscope, we placed a 25 mm × 60 mm WallFlex colonic stent (Boston Scientific, Natick, Mass) across the descending colon stricture under fluoroscopic and endoscopic guidance (Fig. 1B). The ultra-slim colonoscope was then advanced through the descending colon stent to the hepatic flexure stricture, and a guidewire was passed across the stricture under fluoroscopy (Fig. 1C). The ultra-slim colonoscope was advanced simultaneously beside the colonic stent catheter over the guidewire across the descending colon stent to the hepatic flexure stricture, where a 25 mm × 120 mm WallFlex colonic stent (Boston Scientific) was deployed (Fig. 1D and Video 1, available online at www.VideoGIE.org). Postprocedural positioning of the stents was confirmed by abdominal

Written transcript of the video audio is available online at www.VideoGIE.org.

imaging (Fig. 1E). After the procedure, the patient experienced complete resolution of his symptoms.

Our case demonstrates palliative endoscopic options in a patient with malignant large-bowel obstructions. We show that an initial stent placement across the descending colon stricture allowed simultaneous passage of the ultra-slim colonoscope and a stent catheter to place a right-sided colonic stent. It is our opinion that simultaneous passage of the ultra-slim colonoscope alongside the colonic stent catheter allowed for decreased loop formation and easier passage of the colonic stent over the guidewire into the right side of the colon. Endoscopic stenting can be used as a palliative treatment or as a bridge to surgery in patients with malignant colonic obstruction.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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<http://dx.doi.org/10.1016/j.vgje.2017.06.008>