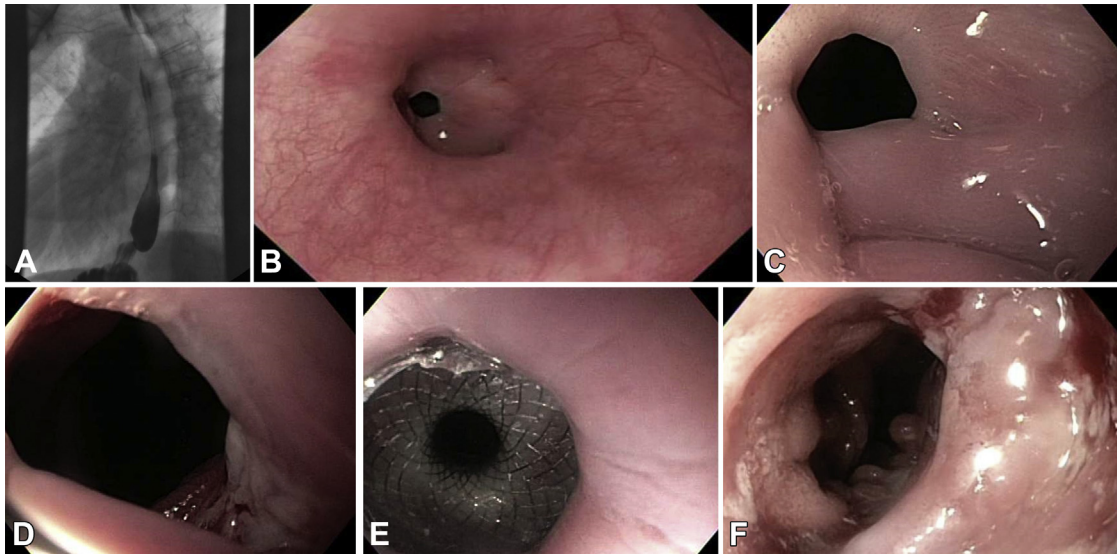


## Management of an esophagojejunal anastomotic stricture using a lumen-apposing metal stent



**Figure 1.** **A**, Esophagram demonstrating the esophagojejunal anastomotic stricture. **B**, Endoscopic view of the esophagojejunal stricture before serial balloon dilation. **C**, Endoscopic view of the esophagojejunal stricture immediately before the second balloon dilation procedure. **D**, Deep submucosal tearing at 5 o'clock position after 12-mm balloon dilation, precluding safe dilation with larger-diameter balloons. **E**, Placement of a lumen-apposing metal stent across the esophagojejunal anastomotic stricture. **F**, Esophagojejunoscopy after removal of lumen-apposing metal stent after a 4-week dwell.

A 56-year-old woman with a history of lupus and laparoscopic Roux-en-Y gastric bypass (RYGB), complicated by a persistent anastomotic ulcer ultimately requiring partial gastrectomy and esophagojejunoscopy, was referred for endoscopic management of an esophagojejunal anastomotic stricture.

Ten years after the RYGB, the patient was evaluated because of epigastric pain and intermittent black tarry stools. She was found to have a bleeding gastrojejunal anastomotic ulcer. She did not report the use of tobacco or significant use of anti-inflammatory agents, and her lupus was known to be well controlled since the time of initial bypass surgery. Because of nonhealing ulceration with associated iron deficiency, persistent epigastric abdominal pain, and 12-pound weight loss, the patient underwent an uncomplicated partial gastrectomy with esophagojejunoscopy. Five months later, the patient was evaluated because of progressive dysphagia. An esophagram (Fig. 1A) and upper endoscopy (Fig. 1B) revealed a benign-appearing esophagojejunal anastomotic stricture approximately 5 mm in initial diameter.

The patient underwent serial balloon dilations to 12 mm (performed every 2 weeks  $\times$  3) (Fig. 1C), without clinical or endoscopic response. Dilation beyond 12 mm was limited by deep mucosal/submucosal tearing (Fig. 1D).

The decision was made to pursue endoscopic placement of a lumen-apposing metal stent (LAMS) (Axios; Boston Scientific, Marlborough, Mass) for management of the refractory anastomotic stricture (Video 1, available online at [www.VideoGIE.org](http://www.VideoGIE.org)). After uncomplicated placement of a 15 mm  $\times$  10 mm LAMS (Fig. 1E), the patient was discharged home, her diet was slowly advanced, and she experienced resolution of her dysphagia. One month after LAMS placement, repeated upper endoscopy was performed, and the stent was removed (Fig. 1F). The anastomosis was widely patent and easily traversed. Five months after LAMS removal, the patient tolerated a nearly normal diet, and her weight had increased by 15 pounds.

In conclusion, LAMS placement may provide an effective management strategy for refractory, short,

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

anastomotic strictures after the failure of serial dilations. Of note, this is an off-label use of LAMSs because they are not approved by the U.S. Food and Drug Administration for this indication.

## DISCLOSURE

*All authors disclosed no financial relationships relevant to this publication.*

**Amy Hosmer, MD, Dmitry Shuster, MD, Anoop Prabhu, MD, Ryan Law, DO, Division of Gastroenterology, University of Michigan, Ann Arbor, Michigan, USA**

Drs Hosmer and Shuster are co-first authors, having contributed equally to this report.

Copyright © 2017 American Society for Gastrointestinal Endoscopy. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

<https://doi.org/10.1016/j.vgie.2017.09.015>