



Figure 1 A scout computed tomogram shows the progression of the migrated double-pigtail endoprosthesis into the right lower quadrant of the abdomen.

Endoscopic ultrasound (EUS)-guided cystogastrostomy has been reported to be a safe and efficient method for drainage of pancreatic pseudocysts [1–3]. More common complications include hemorrhage, perforation, and cyst infection due to stent clogging [3,4]. We report here on a case of small-bowel obstruction caused by migration of a cystogastric endoprosthesis, which was successfully managed without surgery.

A 49-year-old patient was admitted to our institution because of fever and epigastric pain, associated with hyperleukocytosis. His medical history included hypertension, testicular cancer treated by orchiectomy plus chemoradiotherapy, and alcohol-induced chronic pancreatitis complicated by pancreatic and biliary duct strictures, which had required endoscopic stenting. Computed tomography (CT) revealed a 6-cm collection posterior to the antrum, and EUS-guided cystogastrostomy was carried out in order to place a



Figure 2 The transverse computed tomogram shows the stent impacted in the small bowel. The intestine above is dilated.

7-Fr nasocystic drain and, after 1 week, a 10-Fr, 3-cm double-pigtail stent. The patient made an uneventful postoperative recovery and was discharged home 2 days after the procedure. However, 3 weeks later, the patient presented again with intense abdominal pain and nausea. On examination, the abdomen was found to be distended but generally tender, with no evidence of peritonism. CT scanning showed that the prosthesis was impacted in the small bowel, with the intestine above dilated (Figure 1, 2). There was no residual fluid collection. The situation resolved with conservative measures (intravenous erythromycin, analgesics, and nasogastric aspiration), and the patient was discharged home after evacuation of the prosthesis.

Gérolami et al. described a similar case of a patient with pancreatic pseudocyst who presented with intestinal obstruction due to migration of a previously placed cystogastric endoprosthesis and was successfully treated conservatively [5]. In conclusion, bowel obstruction due to the migration of a cystogastric stent is exceedingly rare and can be safely managed without surgery in the absence of any signs of peritonitis. Stent removal is advised after complete resolution of the pseudocyst.

Endoscopy_UCTN_Code_CPL_1AL_2AD

B. Lorenzi, C. Pesenti, E. Bories, F. Caillol, M. Economou, M. Giovannini
Dept. of Endoscopy, Paoli-Calmettes Institute, Marseilles, France.

References

- 1 Binmoeller KF, Soehendra N. Endoscopic ultrasonography in the diagnosis and treatment of pancreatic pseudocysts. *Gastrointest Endosc Clin N Am* 1995; 5: 805–816
- 2 Giovannini M, Pesenti C, Rolland AL et al. Endoscopic ultrasound-guided drainage of pancreatic pseudocysts or pancreatic abscesses using a therapeutic echo endoscope. *Endoscopy* 2001; 33: 473–477
- 3 Giovannini M, Binmoeller KF, Seifert H. Endoscopic ultrasound-guided cystogastrostomy. *Endoscopy* 2003; 35: 239–245
- 4 Binmoeller KF, Seifert H, Walter A et al. Transpapillary and transmural drainage of pancreatic pseudocysts. *Gastrointest Endosc* 1995; 42: 219–224
- 5 Gérolami R, Codoul JF, Heyries L et al. Perforation et occlusion du grêle après migration de prothèse biliaire et de prothèse kystogastrique. *Gastroenterol Clin Biol* 2000; 24: 576–578

Corresponding author

M. Giovannini, M. D.

Paoli-Calmettes Institute
232, boulevard Sainte Marguerite
BP 156 13273 Marseilles Cedex 9
France

Fax: +33-4-91223658

E-mail: hdjchir@marseille.fnclcc.fr