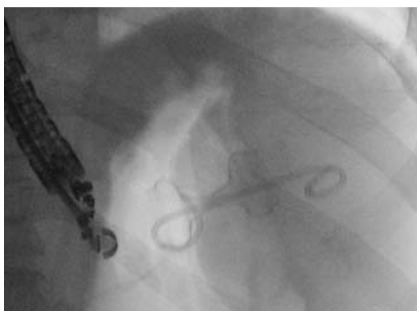


## Endoscopic transgastric extraction of a prophylactic pancreatic single-pigtail plastic stent that had previously migrated into the caudal part of the Wirsung duct

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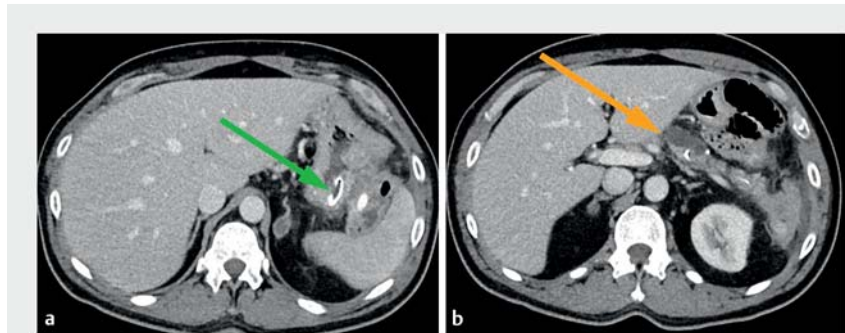


► **Fig. 1** T2 magnetic resonance imaging showing the necrotizing pancreatic collection (red arrow).

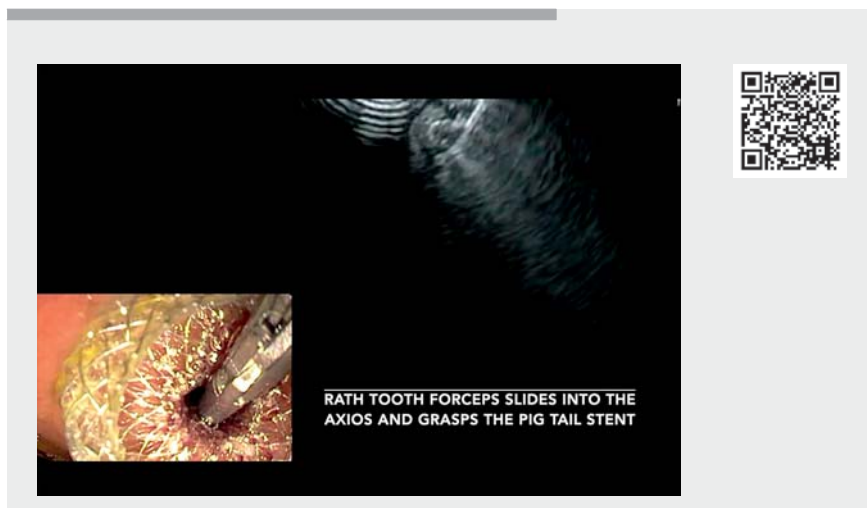


► **Fig. 2** Fluoroscopic image after endoscopic drainage of the collections using a fully covered lumen-apposing metal stent.

We present the case of a 50-year-old patient who had undergone a previous endoscopic ampullectomy. A 5-Fr single-pigtail plastic stent was inserted into the Wirsung duct in order to prevent post-resection acute pancreatitis [1]. Unfortunately, the stent immediately migrated distally into the pancreatic duct, was impossible to extract on endoscopy, and later lead to severe necrotizing pancreatitis of the body and tail of the pancreas. The patient remained septic and the perisplenic necrotic cavities were filled with collected necrotic material (► **Fig. 1**), so we performed endoscopic ultrasound (EUS)-guided drainage using a fully covered lumen-apposing metal stent (LAMS; Axios; Boston Scientific, USA) (► **Fig. 2** and ► **Fig. 3 a**) [2]. Despite this leading to



► **Fig. 3** Computed tomography images showing: **a** regression of the necrotic cavities after endoscopic drainage (green arrow); **b** the distally migrated intrapancreatic plastic stent (yellow arrow), which was in close contact with a corporeal fluid collection.



► **Video 1** Endoscopic ultrasound-guided transgastric extraction of a distally migrated pancreatic plastic stent.

a rapid amelioration of the necrotizing pancreatitis, there remained the problem of the migrated intrapancreatic stent. On computed tomography scanning, we identified a cystic cavity that was in close contact with the distal tip of the pigtail stent (► **Fig. 3 b**). After multidisciplinary discussion, because transpapillary endoscopic stent retrieval was impossible and the patient was not fit for surgery, we

decided to perform endoscopic transgastric extraction of the pigtail stent, in order to prevent further episodes of acute pancreatitis. The cyst was identified on EUS and the distal tip of the pigtail stent was found to be free inside this cavity. A 6-mm LAMS was used to create the communication between the gastric cavity and the peripancreatic cyst and to allow endoscopic access to the tip of the plastic

stent. We then extracted the plastic stent by grasping it with a rat-tooth forceps (Olympus, Japan) that was passed through the LAMS, under fluoroscopic and EUS guidance (► **Video 1**). The metal stent was removed 1 week later and replaced with a double-pigtail plastic stent. No complications were reported.

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### Competing interests

The authors declare that they have no conflict of interest.

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