

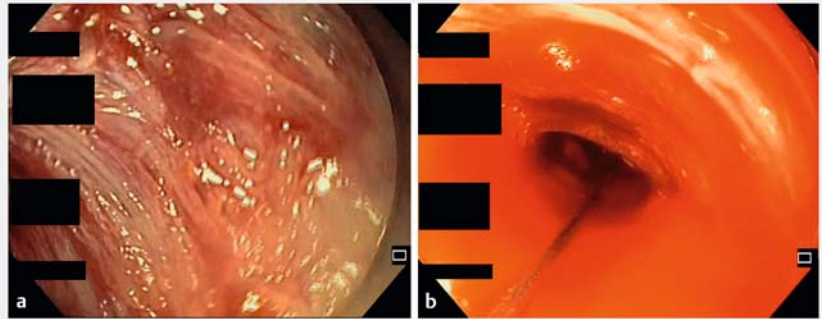
## Endoscopic treatment of complete stripping of esophageal mucosal and submucosal tissue layers

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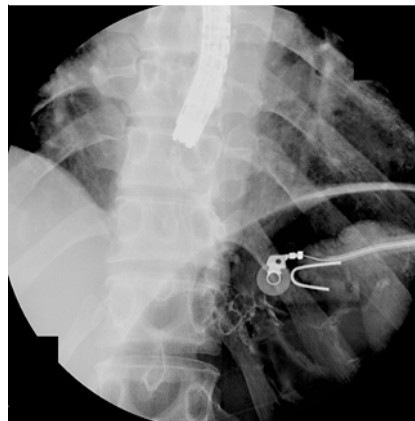


► **Fig. 1** Radiograph showing the migrated self-expandable metal stent (SEMS). It was not possible to pass the endoscope through it.

A 45-year-old woman with advanced lower esophageal cancer was palliatively treated with placement of a partially covered self-expandable metal stent (PCSEMS) and chemoradiotherapy. Removal of the stent was needed 3 months later because of migration and stent ingrowth. We did not use argon plasma coagulation to burn the overgrowth tissue [1] at the edges of the stent because the stent had migrated and it was not possible to pass the scope through it (► **Fig. 1**). Unfortunately, removal of the stent caused a stripping of the esophageal tissue layers. In detail, a 25-cm floppy “sleeve” of esophageal mucosa and submucosa was pulled out with the PCSEMS. The sleeve of tissue was intubated in order to visualize the de-epithelialized



► **Fig. 2 a, b** Upper endoscopy through the “sleeve” of dislocated esophageal mucosal and submucosal tissue, showing the de-epithelialized muscular layer.



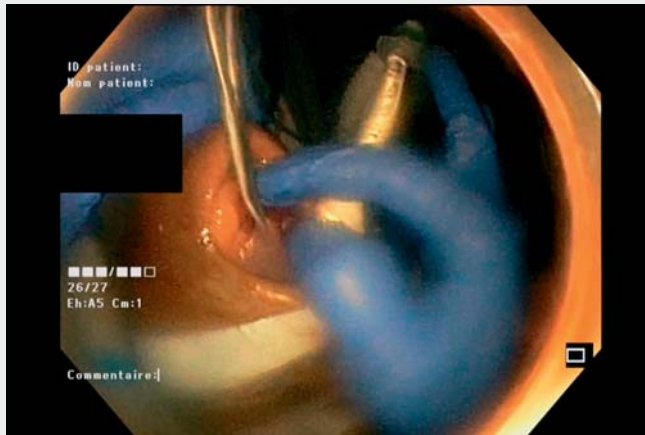
► **Fig. 3** An upper barium swallow study showed no extravasation of contrast medium.

muscular layer (► **Fig. 2**); this layer was not perforated as confirmed later by an upper barium swallow study (► **Fig. 3**). The detached sleeve of esophageal tissue was pushed down again and a 12-cm fully covered SEMS and a nasenteral feeding tube were inserted. However, 4 hours later the patient presented with vomiting and exteriorization of the sleeve of esophageal tissue (► **Fig. 4**, ► **Video 1**). After discussion with otorhinolaryngologists and surgeons, it was decided to endoscopically reposition the stripped esophageal tissue

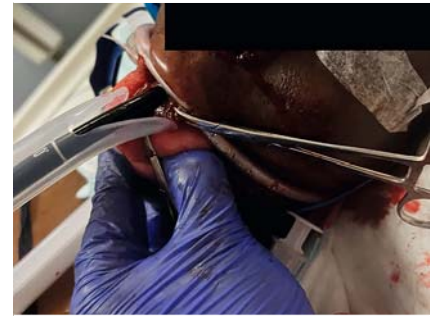


► **Fig. 4** Exteriorization of the sleeve of esophageal tissue through the patient's mouth.

which would otherwise obstruct the patient's airways and laryngeal inlet. The sleeve of tissue was grasped with two Kocher forceps (► **Video 1**) and the scope was inserted through it in order to remove the SEMS. Then, a Devière overtube (Wilson-Cook) was inserted, allowing the tissue sleeve to be pushed completely



▶ **Video 1** A “sleeve” (here termed a “monchon”) of esophageal mucosal and submucosal tissue is pulled out during removal of a self-expanding metal stent (SEMS), and reinserted with the use of an overtube.



▶ **Fig. 5** Insertion of the overtube over the scope allowed the sleeve of esophageal tissue to be pushed down slowly and gently.

down, slowly and gently (▶ **Fig. 5**). A guidewire was passed and a long covered SEMS (17 cm) was left in place between the cervical and lower esophagus together with an NFT. Recovery was uneventful, with oral intake resumed 3 days later.

We describe here an adverse event related to the use of PCSEMS, namely a stripping of superficial esophageal tissue layers, and completely endoscopic treatment of this complication. In conclusion, endoscopist experience and the availability of several endoscopic tools permitted the treatment of this nightmare adverse event in a patient who was not a candidate for surgery.

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### Competing interests

The authors declare that they have no conflict of interest.

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