EP-205 - STENT DISPLACEMENT IN ENDOSCOPIC PANCREATIC PSEUDOCYST DRAINAGE – A RARE COMPLICATION AND AN UNUSUAL ENDOSCOPY MANAGEMENT

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Clinical presentation: A 50-year-old male with a history of acute alcoholic pancreatitis two years before and complaining of abdominal pain performed an abdominal CT scan that revealed a pancreatic pseudocyst with 16x8cm in the tail of the pancreas. After multidisciplinary discussion the patient was referred for endoscopic drainage of the pseudocyst. Transgastric puncture of the pseudocyst was performed with a 19-guage FNA needle, under EUS guidance. A 0.035 inch guidewire was advanced through the needle and the tract was then dilated to a maximum diameter of 6 mm. Following tract dilation, a fully covered double flanged metal stent (4 cm x 14 mm) was deployed across the tract under endoscopic, EUS, and fluoroscopic guidance. The deployment was complicated by complete migration of the stent into the pseudocyst cavity. We decided to place a fully covered biliary metal stent (6cmx10mm) in attempt to both salvage the performed cystogastrostomy and retrieve the migrated stent later. The patient was discharged asymptomatic. One week later the patient was admitted to our department with fever and recurrence of abdominal pain. Abdominal CT scan showed complete migration of the two stents into the pseudocyst cavity (12x6cm). Under endoscopic, EUS, and fluoroscopic guidance, we placed another fully covered double flanged metal stent (4cm x 14mm) through the patent cystogastrostomy. The two intracystic stents were then removed through the last stent using a foreign body forceps. Effective drainage of the pancreatic collection was observed and the patient became asymptomatic. One month later, after an abdominal CT scan showing complete resolution of the pseudocyst, the stent was removed endoscopically.

Discussion: With this case we emphasize the importance of being prepared for complications of endoscopic pancreatic pseudocyst drainage and propose an alternative endoscopic method to solve inadvertent intracystic stent migration, avoiding the surgical intervention traditionally used to treat this complication.