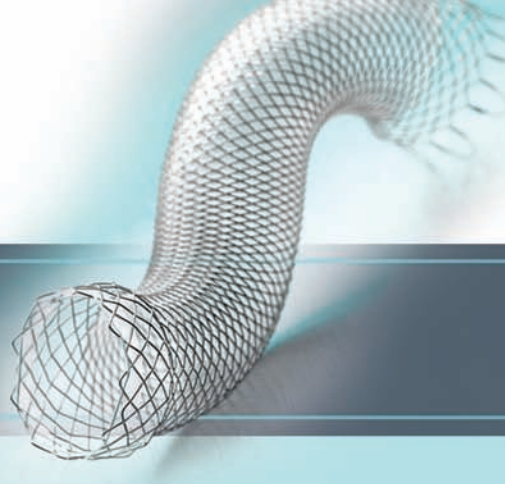
WALLFLEX® PARTIALLY COVERED ESOPHAGEAL STENT
for Recurrent Esophageal Strictures



ED SCHAFER, MD
Co-Director of Endoscopy
The Nebraska Medical Center
Omaha, Nebraska

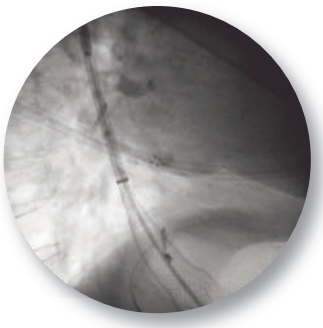


Image 1

HISTORY

A 52-year-old male underwent esophageal resection for adenocarcinoma in 2006. He did well until the onset of dysphagia in July 2008. Initial biopsies were negative for recurrent esophageal CA, however a repeat biopsy with a Radial Jaw® 4 Large Capacity Biopsy Forceps was positive. He became intolerant of his own secretions despite repeat dilations. He was referred for stent placement.

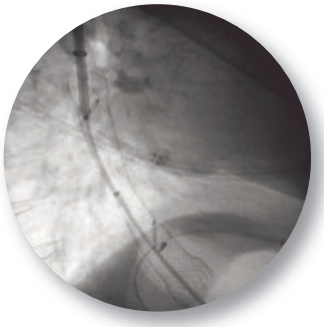


Image 2

PROCEDURE

The recurrent tumor was located quite high at 21 cm. The top area of the tumor was marked with a Resolution® Clip (Image 1) and a guidewire was advanced into the stomach without difficulty. The WallFlex Partially Covered Esophageal Stent was passed through the tumor without dilation (Image 2). The stent was then deployed precisely with the flare of the stent above the tumor but not interfering with the cricopharyngeus muscle (Image 3). Proper location was confirmed endoscopically. The patient tolerated the procedure well.

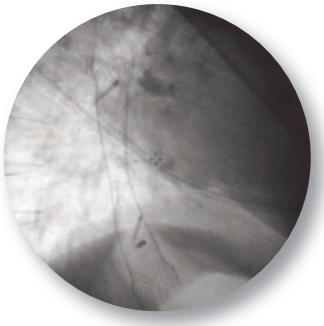


Image 3

POST-PROCEDURE

The patient immediately noticed he was able to swallow his oral secretions and liquids after the procedure and interestingly complained of hypersalivation, which was relieved with one dose of atropine. No aspiration or odynophagia was present, however he did experience some chest discomfort as the stent expanded over the first 24 hours. He was able to advance to a soft diet without dysphagia or aspiration and underwent further therapy for the recurrent tumor.

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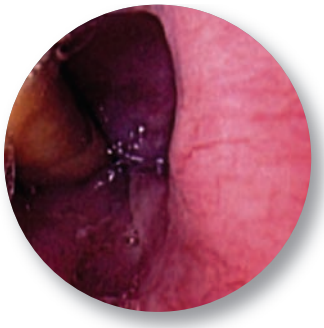

Image 4

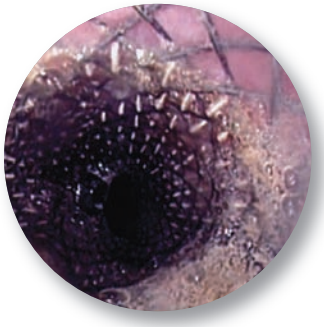

Image 5

DISCUSSION

The 18.5 Fr. Delivery Catheter of the WallFlex Partially Covered Esophageal Stent was flexible and allowed for passage through the tight tumor without pre-dilating and without the need to hyperextend the patient's neck (Image 4). The proximal location of the tumor required precise stent positioning so as not to interfere with the patient's swallowing mechanism. Placement of Resolution Clips to mark the margins of the tumor greatly enhanced accuracy of stent positioning rather than using paperclips taped to the chest. The delivery system of the WallFlex Partially Covered Esophageal Stent enabled precise positioning due to the identification of the proximal and distal stent markers as it was deployed (Image 5).

In my opinion, the WallFlex Partially Covered Esophageal Stent represents a marked improvement in stent technology and may make the gastroenterologist's task easier in difficult situations.

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Boston Scientific Corporation
One Boston Scientific Place
Natick, MA 01760-1537
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