WALLFLEX® PARTIALLY COVERED ESOPHAGEAL STENT

Technique Spotlight



Figure 1



Figure 2



Figure 3



Figure 4



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PATIENT HISTORY & ASSESSMENT

A 71-year-old male presented with progressive dysphagia and weight loss; an initial diagnostic endoscopy revealed a partially obstructing, 7cm long, distal esophageal adenocarcinoma. The proximal end of the tumor was viewed endoscopically (Figure 1). Upon referral we performed an endoscopic ultrasound (EUS) and identified a circumferential uT3uN1 tumor that allowed passage of the ultrasound endoscope with difficulty (Figure 2).

DESCRIPTION OF PROCEDURE

Following the EUS, we passed a 0.035" 280cm hydrophilic stiff wire through an adult upper GI endoscope, measured the length of the tumor, and marked the ends of the stricture with radio-opaque markers on the skin. A 18mm x 123mm WallFlex Partially Covered Esophageal Stent was then partially deployed over the wire with fluoroscopic guidance allowing for proximal repositioning up to 75% if necessary (Figure 3). After the stent was fully deployed, the final position was verified with endoscopy and fluoroscopy. The endoscopic view showed the stent flare at the tumor (Figure 4).

PROCEDURE OUTCOME

The patient was started on high-dose twice-daily proton pump inhibitors and received instructions for aspiration precautions. His dysphagia improved; he complained of mild chest pain that resolved within a few days with oral pain medication.

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DISCUSSION

We chose to use the WallFlex Partially Covered Esophageal Stent in this patient for several reasons:

- Severe stricture: the nitinol structure of the WallFlex Stent conformed well to the esophageal contour and gradually dilated the stricture. Gradual dilation is a desirable property that may avoid the need for balloon dilation.
- 2) Partially covered: we believe that a partially covered stent may delay tumor ingrowth and restenosis.
- 3) Ease and precision of application: the deployment system of the WallFlex Stent is easy to use.



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