

Уважаемые коллеги!

Высылаем очередной выпуск «Issue of ELLA Abstracts»

A. Esophageal Stenting and related topics

A fully-covered stent (Alimaxx-E) for the palliation of malignant dysphagia: a prospective follow-up study

GIE 2009; 70; 6:1082-1089

Madeleen J. Uitdehaag, RN, Msc

Background

The majority of the currently available metal stents are partially covered to reduce migration risk. However, one of the remaining issues is tissue ingrowth through the uncovered stent parts.

Objective

To determine efficacy, recurrent dysphagia, and complications of a fully covered stent, ie, the Alimaxx-E stent, and to compare two stent delivery systems, ie, one introducing the stent over a guidewire and one introducing the stent over a small-caliber endoscope.

Design

A prospective, follow-up study evaluating a new stent design, with randomization for type of introduction system.

Setting

Three tertiary referral centers.

Patients

Forty-five patients with inoperable or metastatic esophageal or gastric cardia cancer.

Interventions

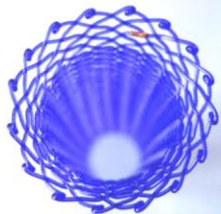
Stent placement.

Main Outcome Measurements

(1) Functional outcome, recurrent dysphagia, complications, and mortality of the Alimaxx-E stent; (2) functional aspects of the delivery system.

Results

At 4 weeks after stent placement, the dysphagia score improved in all patients ($P < .001$). Twenty-two of 45 patients (49%) developed among them 28 episodes of recurrent dysphagia, predominantly stent migration ($n = 16$). Major complications occurred in 9 of 45 patients (20%), with all 5 early (<1 week) complications (severe pain [$n = 3$], hemorrhage [$n = 1$], and fever [$n = 1$]) occurring in patients in whom the stent was introduced over the endoscope ($P = .02$). During follow-up, 44 patients died, 3 (7%) from hemorrhage.



Limitation

The Alimaxx-E stent was not randomly compared with other stent designs.

Conclusions

Placement of Alimaxx-E stents is safe and produces long-term relief of dysphagia, particularly when introduced over a guidewire. The migration rate of the Alimaxx-E stent is, however, unacceptably high, and an adapted stent design is needed.

Stents for the long haul: what do we need?

GIE 2009. 70; 6:1090-1092

Kevin McGrath, MD

The article was published as free. See the enclosure.

Esophageal stenting in children: indications, application, effectiveness, and complications

GIE 2009. 70; 6:1248-1253

Chad Best, MD

Background

Use of esophageal stents is uncommon in children, and there are few reports. We report the first experience in predominantly small children and infants with retrievable, flexible stents designed for tracheobronchial use.

Objective

Evaluation of initial experience with placement of esophageal stents for benign esophageal disorders in children.

Design

A retrospective study.

Setting

A pediatric, academic, tertiary-referral center.

Patients

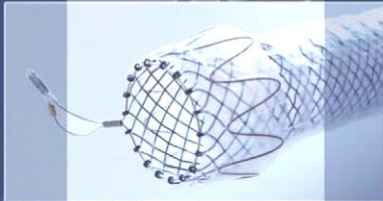
This study involved 7 pediatric patients.

Interventions

Covered tracheobronchial stents were endoscopically placed in pediatric patients with benign esophageal conditions. Removal involved using forceps to pull the purse-string suture into the endoscope channel and collapsing the top of the stent for easy removal.

Main Outcome Measurements

Стенты «Ella-cs»



To evaluate the safety and feasibility of performing endoscopic stent placement in children and to establish criteria for early stent removal.

Results

Six of 7 patients benefitted from stenting. There were no complications of placement. Novel techniques were developed for difficult retrievals. One patient did not benefit from esophageal stent placement, because the stent migrated downward from the uppermost part of the esophagus. One patient had some gagging, which led to early removal of the stent. A stent was removed emergently in 1 patient for respiratory distress.

Limitation

Small number of patients.

Conclusions

Retrievable, covered stents are easily placed and removed from the esophagus in small children. They should be considered for severe unrelenting strictures, especially when associated with esophageal leaks. A need exists for development of esophageal stents designed for pediatric use.

B. Gastric outlet (GO) and duodenal stenting and related topics

Placement of a self-expandable metal stent in a case of malignant stoma stenosis

GIE. 2009. 70; 6:1281-1282

Florian Kreth, MD

The article was published without an abstract.

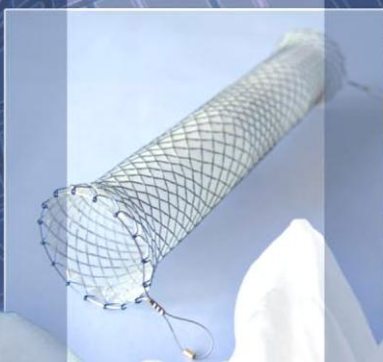
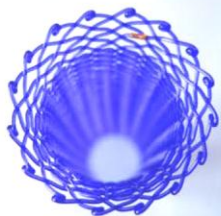
C. Biliary and pancreatic stenting, and related topics

Significant clinical implications of prophylactic pancreatic stent placement in previously normal pancreatic ducts

Endoscopy 2009; 41: 1095-1098

Y. G. Bakman

Pancreatic duct stent placement is increasingly performed for the prevention of pancreatitis after endoscopic retrograde cholangiopancreatography (ERCP); however stents can result in injury especially in normal ducts. The clinical significance and outcomes of subsequent endoscopic therapy are unknown. This study was a retrospective review of the management of symptomatic stent-induced pancreatic duct injury following stent placement for prevention of post-ERCP pancreatitis in eight patients with previously normal pancreatic ducts. Subsequent treatment included pancreatic sphincterotomy, balloon dilation of stricture, and placement of multiple 3 - 5-Fr soft polymer pancreatic stents. All patients showed improvement or resolution of pancreatic strictures. Five patients had resolution or substantial improvement of pain, one patient showed a fair response with repeated ERCPs, and two patients failed to respond and underwent total pancreatectomy with islet autotransplantation. Pancreatic duct stent-induced ductal injury with significant clinical consequences can occur with conventional polyethylene stents. Endoscopic therapy is moderately effective but some patients develop irreversible damage. Caution should be used



when placing standard polyethylene stents in normal ducts. Further research is required to identify safer materials and configurations of pancreatic stents.

Usefulness of slimmer and open-cell-design stents for endoscopic bilateral stenting and endoscopic revision in patients with hilar cholangiocarcinoma

GIE 2009; 70; 6:1109-1115

Jeong Yeol Kim, MD

Background

Although endoscopic bilateral metal stenting using a “stent-in-stent” method is currently used to treat patients with unresectable hilar cholangiocarcinoma, this method has limited application in cases of tight strictures or endoscopic revision in case of tumor recurrence, especially on the first stent (initial Y stent placed) side.

Objective

To evaluate the clinical efficacy of bilateral metal stenting with the use of a slimmer (7F), open-cell-design stent.

Design

Prospective, uncontrolled, single center.

Setting

Tertiary referral university hospital.

Patients

This study involved 34 patients with unresectable hilar cholangiocarcinoma (Bismuth type II-IV).

Intervention

Endoscopic bilateral metal stenting using a stent-in-stent method was performed. First, a Y stent with a central, wide-open mesh was inserted, then a Zilver stent, with a preloaded delivery system that is slimmer (7F) than those (7.5-8.5F) of conventional stents, was placed into the contralateral hepatic duct through the central portion of the Y stent. The Zilver stent has an open-cell design, and it can be dilated easily. Thus, revision with bilateral plastic stents was tried in cases of stent obstruction.

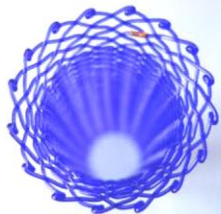
Main Outcome Measurements

Technical success, functional success, complications, and revision method.

Results

Technical success (bilateral stenting using Y and Zilver stents) was achieved in 29 of 34 (85.3%) patients. Functional success was noted in 29 of the 29 (100.0%) patients who received bilateral stenting. Early complications such as pancreatitis and cholecystitis occurred in 3 (10.3%) patients. Late complications occurred in 11 (37.9%) patients. Cholecystitis, which occurred in 2 patients, was managed by percutaneous transhepatic gallbladder drainage. Stent obstruction by tumor ingrowth or

Стенты «Ella-cs»



overgrowth occurred in 9 of 29 (31.0%) patients. These patients were managed by placement of bilateral plastic stents (4 of 9), percutaneous transhepatic biliary drainage (4 of 9), and a combined method (1 of 9). Of the 5 patients in whom endoscopic revision was attempted, 4 (80%) were managed endoscopically with bilateral plastic stents.

Limitations

Small number of patients, uncontrolled study.

Conclusion

A slimmer (7F), open-cell-design stent is effective in endoscopic bilateral stenting for advanced hilar cholangiocarcinoma and endoscopic revision in case of tumor recurrence.

