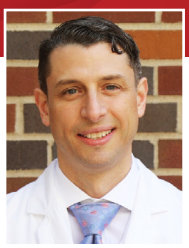
CASE STUDY

Palliative management of a stenotic esophageal malignancy with EndoMAXX®

MERIT MEDICAL ENDOTEK®



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PATIENT HISTORY

A 76-year-old gentleman with progressive solid food dysphagia and a long history of tobacco use was found to have a malignant appearing, partially obstructing mass spanning 1-2cm of the mid esophagus (Fig 1A) with biopsies demonstrating poorly differentiated adenocarcinoma. Subsequent imaging revealed liver metastases confirming Stage IV disease. Oncology referred the patient for indefinite palliative esophageal stent placement to allow improved oral nutrition and quality of life while undergoing chemotherapy.

PROCEDURE

With the patient supine and under general anesthesia, an adult gastroscope is passed to reevaluate the mass (Fig 1A). The location and length of the malignant stenosis are confirmed and anatomic landmarks, along with an external marker, are utilized for subsequent positioning of a 23x70 mm covered metal EndoMAXX stent over a long 0.025" guidewire (Fig 1B). Using fluoroscopic guidance, the laser-cut stent is deployed, centering on the stenosis with at least 2cm of widely expanded stent above and below the lesion (Fig 1C). Relook endoscopy demonstrated immediate expansion with appropriate seating against the mucosa as well as a tight waist at the stenosis (Fig 1D).

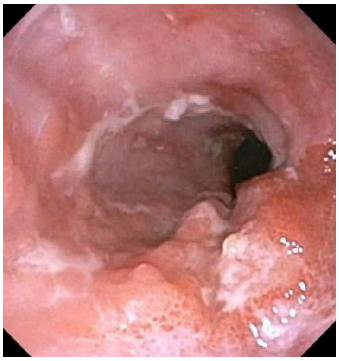

Figure 1A

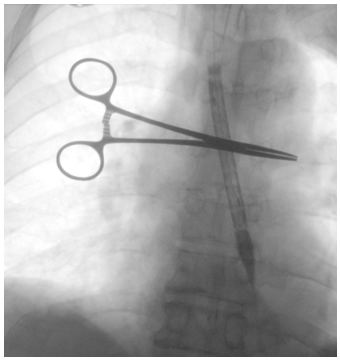

Figure 1B

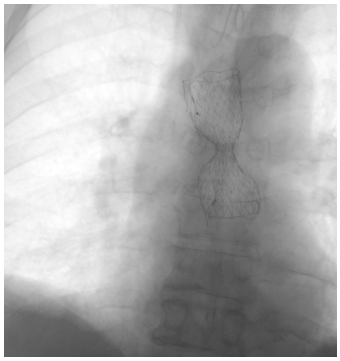

Figure 1C

Figure 1D

With no complications and ongoing efficacy, the patient returned every 8 weeks for the remainder of his life for scheduled stent exchange. On return visits, the previously deployed stent was demonstrated to be well expanded and stable in position both endoscopically and fluoroscopically (Fig 2A, 2B) in part due to the unique anti-migration struts. To remove the EndoMAXX stent, the proximal purse string suture is grasped with rat-toothed forceps allowing for collapse of the proximal end, limiting trauma on removal (Fib 2C). Prior to replacement of another 70 mm EndoMAXX stent, the site of previous placement is evaluated and found to reveal minimal surrounding tissue damage (Fig 2D).

CONTINUED

Figure 2A

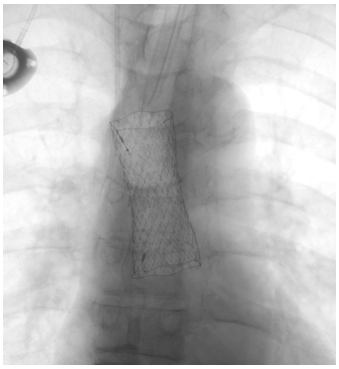

Figure 2B

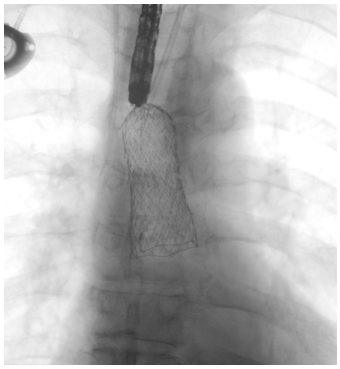

Figure 2C

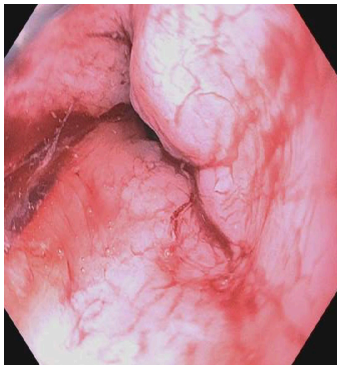

Figure 2D

KEY TAKEAWAYS

The laser-cut design expands immediately on deployment at near final length and position with minimal to no foreshortening, improving accuracy of placement.

Metal sutures at both ends allow confident repositioning as well as invagination of the distal end on removal.

Anti-migration struts help increase mucosal contact and decrease downward migration, while not complicating removal.

"The near immediate expansion combined with the unique struts tempers unwanted migration over time."
—Stuart Amateau, MD PhD

EndoMAXX®