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P 118. COLONIC STENT PRESENTING WITH STENT IMPACTION AND EROSION THROUGH THE COLONIC WALL

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Background: Colonic stenting has been shown to be effective as a palliative measure in colorectal cancer when patients present with obstructing symptoms. However, its efficacy when used for complications of colonic anastomoses are less well-studied. We present a case report of an elderly gentleman with a colonic stent placed for an anastomotic stricture, which led to stent migration and stent impaction with erosion in the sigmoid colon.

A 92-year-old gentleman presented to the ED with several days worth of nausea and vomiting. He had recently undergone a partial colectomy with an ileocolonic anastomosis approximately one year prior and then had a covered metal colonic stent placed at an outside institution three months prior to his presentation. At our facility, a CT scan was obtained which showed migration of the colonic stent into the sigmoid colon along with a transition point proximal to that location. Conservative management was attempted, but after 24 hours the patient was continuing to have nausea and emesis with new-onset obstipation. The decision was then made to proceed with an exploratory laparotomy. Intra-operatively, the patient was found to have a severely strictured anastomosis with the stent impacted in the sigmoid colon. It was also noted that the stent had eroded through the colonic wall and was infiltrating the pelvic sidewall. The sigmoid colon was dissected free from the area and an en bloc resection of the sigmoid colon and the previous anastomosis was then done. A small bowel to sigmoid colon anastomosis was then created. The patient tolerated the procedure well and was discharged home on post-operative day three.

Colonic stenting for benign pathology is a debated topic with sparse literature delineating when it is appropriate. Stenting for benign colorectal disorders may be appropriate in the correct clinical setting, such as a patient who is not a surgical candidate, but there is a lack of long-term data on its efficacy. A well-known complication of colonic stenting includes stent migration which Eubanks and colleagues noted to be present in 58% of the 34 stents they placed for gastrojejunal anastomotic complications. Usually stent migration can be effectively managed with endoscopic stent extraction, but our case illustrates the dangers of stent migration, as surgical intervention may be necessary for retrieval.

While colonic stenting of non-malignant pathology may be appropriate in patients who are non-operative candidates, complications such as stent migration can have deleterious effects requiring operative exploration.