University Hospitals of Derby and Burton NHS Foundation Trust

Oesophageal and Duodenal Stent Insertion – Summary Clinical Guideline

Reference No: CG-T/2014/147

Indications

The main use for G I stents is in malignant strictures in the oesophagus and pylorus. Stents may also be used to treat refractory benign strictures, to cover perforations, and to treat bleeding varices (Dannis stent).

Workup

Prior to elective stent insertion patients should be

1. seen in clinic
    a. the risks of stenting explained including
        i. aspiration pneumonia,
        ii. perforation,
        iii. pain following insertion,
        iv. bleeding,
        v. displacement,
        vi. unsuccessful insertion.
    b. CT chest
        i. Patients with oesophageal malignancy should have up to date CT chest to assess the risk of bronchial or tracheal compression by the oesophageal stent. Stenting of the oesophagus is contraindicated in the presence of tracheal or bronchial stenosis secondary to the tumour.
    c. Assess location of upper end of stent.
        i. Sufficient space for placement of high stents above the stricture needs to be allowed. Typically stents would not be placed if the stricture is less than 2 cm below the crycopharyngeal sphincter. If in doubt a removable stent can be used.
    d. Choice of stent planned.
        i. SCC use covered ultraflex preferred
        ii. Adenocarcinoma – use ultraflex uncovered as least risk of displacement.
        iii. Benign disease or need to remove stent use Hannaro or equivalent fully covered removeable stent. Or in special circumstances SX-ELLA biodegradeable stent.
    e. Is imaging needed if so book room 7 and radiographer (combined endoscopic and image guided stents) or book Xray for Xray only stents.

Stent Insertion.

Patients for stents need to have :

1. an INR checked
2. Stop anticoagulants as per anticoagulant guidelines.

3. A bed for post stent recovery- 10% of patients require a period of post stenting pain relief.
4. Inform upper GI CNS and Dietetics.

Endoscopy

Book with endoscopy using endoscopy request form. INDICATE IF X-RAY IMAGING NEEDED AND DISCUSS THIS WITH ENDOSCOPY NURSE COORDINATOR IF NECESSARY.

Stents are usually inserted under direct vision and wire guided. The stomach is entered using either a ultraslim (6mm) endoscope or a standard scope and TTS balloon used to gain access to the stomach, a guide wire placed and the stent then placed over the guide wire and positioned under endoscopic guidance. BSG guidelines to avoid topical anaesthetics combined with sedation should be followed to avoid the risk of aspiration pneumonia.

Radiology

Book using iCM for interventional procedures. Must be discussed with GI radiologists.

Joint

Certain cases e.g. difficult duodenal stents are best done as combined procedures. This needs liaison between endoscopy and radiology consultants. The Gastroenterologist will liaise with the Radiologist and Endoscopy. A yellow endoscopy request form is still required.

Aftercare

Stent patients will require:

1. A specialist diet – dietetic review is mandatory – see post stent diet sheet on intranet.
2. All patients with stents across the cardia will need high dose PPI therapy as the stent will allow free gastro oesophageal reflux.

Complications

i. aspiration pneumonia,
ii. perforation,
iii. pain following insertion,
iv. bleeding,
v. displacement,
vi. unsuccessful insertion,
vii. bolus food obstruction,