Colonic stenting
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• Introduction
• General considerations
• Technical considerations
• Indications
  – Palliation
  – Bridge to surgery
• Oncological impact
• Adverse events
• Take home
Contraindication for colonic stenting:

- **Absolute:**
  - Suspicion of perforation

- **Relative**
  - Lack of obstructive symptoms
  - Peritoneal carcinomatosis
  - Tumors close to the anal verge (< 5 cm)
• **Type of stent**
  - Covered vs uncovered
    • Clinical and overall complications equal
      - Ingrowth 0.9% vs 11.4% and migration 21.3% vs 5.5%
  - Diameter
    • < 24 mm associated with the occurrence of complications

Zhang et al., Colorectal Dis 2012
Yang et al., Int J Med Sci 2013
Kim et al., J Dig Dis 2012
Manes et al., Arch Surg 2011
Small et al., Gastrointest Endosc 2010
Im et al., Colorectal Dis 2008
Technical considerations

• Type of stent
  – Length
    • No difference in outcome
  – Design
    • No difference in outcome

Yoon et al., Gastrointest Endosc 2011
Selinger et al., Int J Colorectal dis 2011
Abbott et al., Br J Surg 2014
Geraghty et al., Colorectal dis 2014
New data on palliation
New data on palliation

• Summary

“There is no proven advantage with regard to overall mortality and morbidity and data on effectiveness are contradictitious, but SEMS do have some specific advantages (shorter hospital stay, less stoma creation etc.) for palliation of incurable CRC”
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New data on bridge
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New data on bridge

• Summary

“Colorectal stenting is as safe as emergency surgery with regard to mortality and appears to have a more favorable overall complication profile and decreases the permanent stoma rate”
Oncological impact

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• Summary

In the palliative setting chemotherapeutics do increase survival but at the expenses of reintervention.

In the curative setting SEMS might impair survival and increase (local) recurrence.
• SEMS for malignant colonic obstruction
  – Early adverse events (≤ 30 days)
    • Perforation  0-12.8%
    • Stent failure  0-11.7%
    • Pain  0-7.4%
    • Stent migration  0-4.9%
    • Reobstruction  0-4.9%
    • Bleeding  0-3.7%

ESGE clinical guideline on SEMS for obstructing colonic cancer, Van Hooft et al., Endoscopy submitted
Adverse events

• SEMS for malignant colonic obstruction
  – Late adverse events (≥ 30 days)
    • Reobstruction  4-22.9%
    • Migration      1-12.5%
    • Perforation    0-4%

ESGE clinical guideline on SEMS for obstructing colonic cancer, Van Hooft et al., Endoscopy submitted
Adverse events

- Effect of sum of complications
  - 30-day mortality <4%
  - Stent patency
    - Palliation: Median 160 d (68-288 d)
    - 80% (53-90%) until death
    - Bridge: Large majority

ESGE clinical guideline on SEMS for obstructing colonic cancer,
Van Hooft et al., Endoscopy submitted
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- Technical considerations
- Indications
  - Palliation
  - Bridge to surgery
- Oncological impact
- Adverse events
- Take home
Summary

• General considerations
  – Contraindication for colonic stenting
  – Primary diagnostic tool
  – Pathological conformation
  – Preparation of obstructed patients
  – The operator

• Technical considerations
  – Stent placement technique
  – Type of stent
• Palliation
  – No proven advantage regarding overall mortality and morbidity
  – Data on effectiveness contradictory
  – Clear advantage regarding
    • Hospital stay, stoma formation, time to chemotherapy
  – Oncological impact (chemotherapy)
    • Better survival
    • More reinterventions
Summary

• **Bridge**
  – No proven advantage regarding overall mortality
  – More favorable overall complication profiles
  – Decrease permanent stoma rate
  – Oncological impact
    • Might impair survival
    • Increase (local) recurrence
ありがとうございます
Arigato * Thank You