A 40-year-old man presented with dysphagia of 2 months' duration. Gastroscopy revealed ulceroproliferative growth in the mid-thoracic and lower-thoracic esophagus (Fig. 1). A biopsy specimen showed squamous cell carcinoma. The patient underwent positron emission tomography (PET) CT for staging of the disease. PET revealed growth in the midlower esophagus. A few gastrohepatic lymph nodes were present. There was another metabolically active lymph node (1.2-cm diameter) in the left para-aortic region just below the level of the left renal vein (Fig. 2). This lymph node raised a clinical dilemma. A malignant lymph node in this region would
mean metastatic disease, and the patient would require chemotherapy with palliative intent. However, if the node was benign (inflammatory, as is common in our country), the patient would be a candidate for neoadjuvant chemotherapy.

Because the radiologist could not confirm the nature of the lymph node (inflammatory or malignant) on the basis of the PET CT findings, the patient was referred to us for EUS-fine-needle aspiration cytology (FNAC). However, the echoendoscope could not be negotiated across into the stomach even after the stricture was dilated up to 15 mm because the stricture was tight, and the tumor began bleeding (Fig. 3).

Because it was clinically important for the oncologist to sample the lymph node, a novel way of sampling the node was planned. The patient was offered the opportunity to undergo esophageal stent placement with fully covered esophageal self-expandable metal stent. Because the stent diameter is 18 mm, once the stent is fully expanded the echoendoscope should be easily negotiated into the stomach. If the node turned out to be malignant on FNAC, the disease would be proved metastatic, and the stent would be left in situ for palliation of dysphagia, as is usually done in cases of metastatic carcinoma of the esophagus. However, if the node was benign, the stent would be removed before surgery.

The patient agreed to the above plan. Esophageal stent placement was performed (Fig. 4). A 12-cm fully covered esophageal stent (Bonastent; Sewoon Medical, Seoul, Korea) was placed across the stricture. This stent has an 18-mm diameter in the shaft of the stent with 22-mm flares at both ends.

After 4 days, when the esophageal stent had fully expanded as shown by fluoroscopy, EUS was planned
A guidewire was passed across the stent into the stomach (Fig. 5). The echoendoscope (maximum outer diameter 14.6 mm) was introduced over the guidewire under fluoroscopic guidance (Fig. 6). The guidewire technique was used for additional safety to prevent the endoscope from accidentally impinging on the stent. The endoscope was easily negotiable across the stent.

EUS-guided FNAC was performed from the left lower para-aortic lymph node (Fig. 7), and cytologic analysis confirmed metastatic squamous cell carcinoma (Fig. 8). The stent was left in situ for palliation of dysphagia. FNAC was performed successfully, and there were no adverse events; there was no migration of the stent by the echoendoscope, nor was there damage to the endoscope.

Performance of intra-abdominal FNAC in case of stricturing lesions of the esophagus is difficult because of the risk of esophageal perforation by the large-caliber oblique-viewing echoendoscope. Dilation of the stricture also does not help in the majority of cases. The use of an esophageal stent (as in the case described here) can help in the safe performance of EUS-guided FNAC of intra-abdominal lymph nodes, which has significant clinical ramifications.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

Abbreviations: FNAC, Fine-Needle Aspiration Cytology; PET, positron emission tomography.