A 65-year-old man had experienced severe alcoholic pancreatitis 5 weeks earlier and was treated in another hospital. Although the acute pancreatitis was treated with conservative therapy, the patient had a high fever with abdominal pain for 1 week. The laboratory test showed elevated C-reactive protein (30.5 mg/dL). The CT and EUS findings showed an encapsulated collection, measuring 230 × 76 mm, with debris (Fig. 1). According to the clinical course and image findings, an infected walled-off necrosis (WON) was suspected.

An EUS-guided (GF-UCT240; Olympus Medical Systems, Tokyo, Japan) pancreatic fluid collection drainage by use of a 15-mm lumen-apposing metal stent (LAMS) (Hot Axios; Boston Scientific, Marlborough, Mass, USA) was planned for the infected WON. The WON was punctured with the electrocautery tip after confirmation of the vessels of the

Figure 1. A, Contrast-enhanced CT view showing the largely encapsulated collection with enhancing wall in the bed of the whole pancreas. B, EUS view showing the debris in the encapsulated collection.

Figure 2. EUS view showing deployment of the distal flange of the lumen-apposing metal stent in the walled-off necrosis.
The distal flange was deployed in the WON under EUS imaging (Fig. 2); next, the proximal flange was deployed in the gastric lumen. A double-pigtail plastic stent (DPS) was placed inside the LAMS to prevent food material entering into the WON (Fig. 3). After placement of the LAMS, endoscopic necrosectomy (EN) was performed. We first used a snare for polypectomy in the EN to avoid catching the LAMS. However, the necrotic tissue was spongy and solid, and it was difficult to catch it with the snare. The WON cavity was filled with the necrotic tissue, the EN was hard to perform, and the DPS also interfered with the endoscope. Therefore, it was necessary to remove the DPS during each EN procedure.

We were able to catch the necrotic tissue by using 5-prong forceps (Olympus) (Fig. 4), and it was easily removed with the forceps. However, the forceps incidentally caught the distal-side flange of the LAMS, which migrated to the gastric lumen. At first, we tried...
to replace the LAMS using the rat-tooth forceps. We caught the distal flange and tried to insert it into the fistula. However, because the distal flange hit against the gastric wall, the LAMS could not be replaced into the fistula.

Next, we removed the LAMS through the endoscope using a 10-mm snare (Olympus). We inserted the 10-mm snare into the LAMS and grasped the distal flange. The wire of the snare was carefully slid to the end of the LAMS. After this, we changed to a large 3.7-mm channel gastroscope (GIF 2T240) (Olympus). The grasped LAMS was inserted into the WON cavity from this large gastroscope channel, and the snare was carefully opened to deploy the distal end of the LAMS (Video 1, available online at www.VideoGIE.org). Finally, we rectified the position of the LAMS using rat-tooth forceps.

The replaced LAMS had no breakage and was fastened in the fistula until the EN procedure was accomplished. The replaced LAMS was easily removed after EN, and the fistula had no damage after removal. The fistula closed spontaneously 4 days later. There was no adverse event until the final EN. The CT scan after 1 month from the final EN showed the disappearance of the WON cavity without any adverse event (Fig. 5).

**DISCLOSURE**

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**REFERENCE**

1. Aburajab M, Smith Z, Khan A, et al. Safety and efficacy of lumen-apposing metal stents with and without simultaneous double-pigtail plastic stents for draining pancreatic pseudocyst. Gastrointest Endosc 2018;87:1248-55.

**Abbreviations:** DPS, double-pigtail plastic stent; EN, endoscopic necrosectomy; LAMS, lumen-apposing metal stent; WON, walled-off necrosis.

Figure 5. CT scan 1 month after the final endoscopic necrosectomy, showing disappearance of the cavity of the walled-off necrosis.