CHALLENGES ASSOCIATED WITH LOW RECTAL MALIGNANT OBSTRUCTION STENTING

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BACKGROUND

- There is ongoing debate regarding whether self-expanding metallic stent (SEMS) placement within 5 cm of the anal verge is feasible.
- Traditionally, SEMS has been considered contraindicated for patients with malignant rectal obstruction within 5 cm of the anal verge because of potential impact on the anorectal ring or within the anal canal, causing incontinence, proctalgia and tenesmus.

CASE PRESENTATION

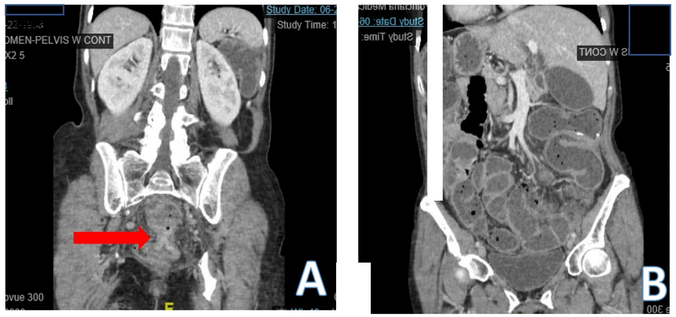
The patient is a 63-year-old female who presented with distention, abdominal pain, and diminishing stool output. Rectal exam identified a bulky fixed mass. Imaging studies revealed large bowel obstruction and high-grade distal rectal stricture, with a miniscule residual lumen, **(Imaging 1 and 2).**

Endoscopy identified a bulky mass obscuring the lumen at 5cm from the anal verge **(Imaging 3)**. Biopsy identified adenocarcinoma. 1.5 Tesla Pelvic MRI demonstrated an apple core lesion, staged at least mT3N0.

A 2.5cm x 9.0cm colonic stent was deployed with brisk colonic decompression **(Imaging 4).** She had voluminous fecal incontinence for 12 hours before spontaneous resolution. Prior to discharge a contrast enema demonstrated stent patency and excluded synchronous lesions. She was promptly able to undergo chemoradiotherapy.

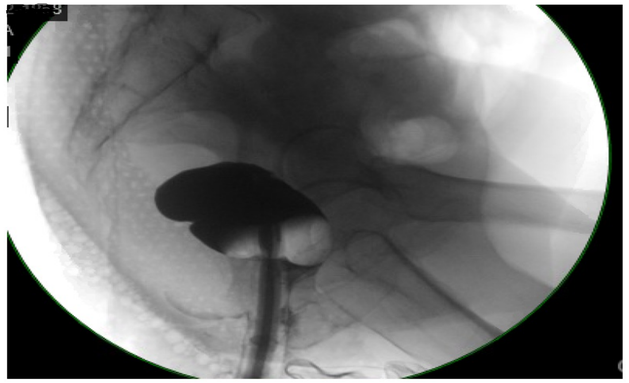
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RADIOGRAPHIC IMAGING



Imaging 1:

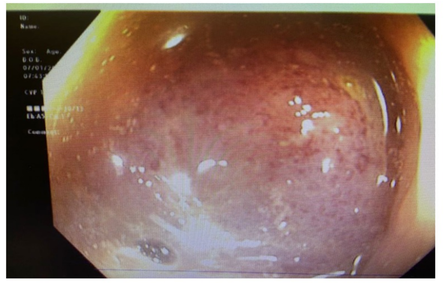
Abdomen and Pelvis CT scan, coronal view (A) demonstrate low rectal concentric and symmetric near obstructing stricture indicated with the red arrow. Coronal view (B), demonstrate a diffuse colonic and small bowel dilation consistent with LBO.



Imaging 2:

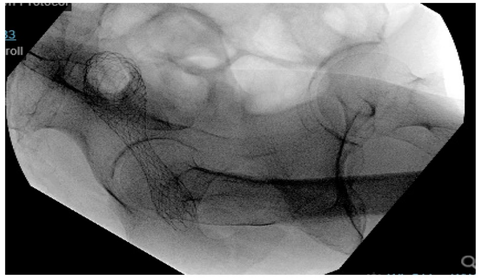
Contrast enema showing no retrograde filling due to low rectal stricture

ENDOSCOPIC MANAGEMENT



Imaging 3:

Colonoscopy demonstrate fixed bulky near obstructing mass



Imaging 4:

Endoscopic 2.5cm x 9cm Wall Flex low rectal stent placement under fluoroscopy guidance.

DISCUSSION

Historically, SEMS has been avoided in low rectal position lesions. Our case is an example of the uncommon complication of self-limited fecal incontinence with very low rectal stenting. The substantial potential energy stored in a distended colon rapidly dissipates through the relatively generous caliber stent. This pressure head overwhelms the short distal rectal segment resulting in anal incontinence, until the pressure equilibrates across the stent. In this patient, we were only able to deploy just above the anorectal ring. She had been consented for a transanal revision of the stent, we would have truncated the caudal aspect of the stent, if necessary.

This case illustrates stenting can be very effective in the low rectum. However, it has a greater technical challenge and patient teaching requirement. The risk of transient incontinence, proctalgia and tenesmus is greater in this position. As more easily removeable metal stents become more commonplace, more endoscopists may be willing to place stents in this previously relatively contraindicated position.