Introduction

The word “stent” derives from the name of an English dentist, Charles Stent (1807 – 1885), who invented a compound for dental impression in 1856 [1]. This compound was then used for plastic surgery during the First World War (it served as a matrix around which to form tissue in the process of rebuilding a shattered face). “Stent” is currently used to describe hollow tubes made of plastic or of metal that are implanted into a variety of anatomical locations, most commonly vessels and urological/digestive tracts.

Biliary stents are used to facilitate the drainage of bile into the digestive tract, most frequently in the palliation of malignant biliary obstruction but also in benign conditions such as biliary fistulas or benign biliary strictures. This article is part of a publication that expresses the current view of the European Society of Gastrointestinal Endoscopy (ESGE) about endoscopic biliary stenting: a technology review describes the stent models and stenting techniques, and a separate clinical guideline states the evidence and recommendations regarding stenting.

Methods

The ESGE commissioned and funded these guidelines after preliminary work from the French Society of Digestive Endoscopy [2]. For the technology review, the methodology was adapted from that used for ESGE clinical guidelines: notable differences include the absence of key questions and of recommendations [3]. Briefly, a search of the relevant literature was performed in Medline (via Pubmed), the Cochrane Library, Embase, and the internet, with search terms that always included at least “biliary” and “stent” plus words pertinent to specific topics.

The following manufacturers were contacted by the Secretariat of the ESGE to collect technical information about self-expandable metal stents (SEMSs), with a maximum of two covered and two uncovered models allowed per manufacturer: Abbott Vascular (Abbott Park, Illinois, USA), Boston Scientific (Natick, Massachusetts, USA), Conmed (Utica, New York, USA), Cook Endoscopy (Winston-Salem, North Carolina, USA), C. R. Bard (Murray Hill, New Jersey, USA), Edwards LifeScience (Irvine, California, USA), ELLA-CS (Hradec Kralove, Czech Republic), ev3 Endovascular (Plymouth, Minnesota, USA), Gore Medical (Flagstaff, Arizona, U.S.A), Leufen Medical (Aachen, Germany), Medinol (Jerusalem, Israel), M.I.Tech (Seoul, Korea), Optimed (Ettlingen, Germany), Sewoon Medical (Seoul, Korea), Standard ScienceTech (Seoul, Korea), Stentechnic (Seoul, Korea), Tae-woong (Seoul, Korea). If there was no response, the query was repeated by the first author.

In November 2010, the manuscript was endorsed by the ESGE Governing Board. It was sent to the Editorial Board of the journal Endoscopy for international peer review, and the final version was approved by all authors.
Plastic stents

Stent characteristics
Shape and material
Most models of plastic stents are slightly curved to fit the contour of the common bile duct (CBD) and to prevent stent migration; S-shaped stents are specifically designed for draining the left biliary tree and pigtail stents are also available, but these latter models are rarely used in the bile ducts (Fig. 1).

Sideholes are present at both ends of many stent models in order to maintain drainage if the tip of the stent becomes impacted in the biliary or digestive tract wall. As it has been suggested that these sideholes favor sludge formation [4], models without sideholes but with multiple sideflaps intended to prevent stent migration have been developed (these are known as “Tannenbaum” stents, from the German word for firtree). The Double Layer stent is an example of the Tannenbaum design. Attempts to prolong stent patency, by the addition of an antireflux valve or by the use of different coatings on the stent surface, are being tested [5,6]. Most “plastic” stents are made of polyethylene, Teflon, or polyurethane. Polyethylene stents become malleable (in other words, their shape may be changed) when immersed in boiling water; they are softer than Teflon stents.

Stent diameters
The diameter of plastic biliary stents is measured in French (Fr), a unit that corresponds to one third of a millimeter. Standard external diameters of plastic biliary stents are 7.0, 8.5, 10.0, and 11.5 Fr; it would be difficult or impossible to introduce larger stents through most standard therapeutic duodenoscopes with working channels that measure 4.2 mm in diameter.

Stent lengths
Standard plastic stent models are available in lengths ranging between 5 and 18 cm but custom-made stents may be ordered from some manufacturers (longer models may be useful in liver transplant recipients). Of note, the stated length usually indicates the distance between the proximal and distal flaps of the stent, not the entire stent length, but this is not true for all models.

Technique of plastic stent insertion
Material
This includes the following:

- Radiopaque guide wire. The numerous available models have been described in two recent technological evaluations [7,8]. The most popular “hybrid” models have a hydrophilic tip to facilitate passage of tight or tortuous strictures and a stiffer shaft to provide good “trackability.”

- Short-wire systems are available from three manufacturers, Boston-Scientific, Cook Endoscopy, and Olympus (Tokyo, Japan). These systems include a locking mechanism to prevent the wire from slipping during exchange procedures and a short wire (185–270 cm in length as compared with the usual 400–600 cm). In two randomized controlled trials (RCTs) some of these systems allowed significant reduction in the time needed for device exchange and for stent insertion compared with traditional long-wire devices [9,10]. One of these systems (Fusion; Cook Endoscopy) also allows for intraductal exchange (i.e., removing a catheter while leaving the supporting guide wire in the bile ducts), a characteristic that may facilitate insertion of multiple plastic stents [11].

Methods
Plastic biliary stents are placed with their distal end protruding into the duodenum, because stent placement beyond the sphincter of Oddi rather than across it does not prolong stent patency and increases the risk of stent migration [13]. Stent length is generally selected as the shortest possible that will still ensure adequate drainage. Stents are usually positioned so that one end is 2 cm beyond the proximal extent of the biliary obstacle and the other end protrudes 1 cm into the duodenum (a long intraduodenal stent portion may cause peritoneal or retroperitoneal perforation and bleeding ulcer) [14]. Stents with sideflaps designed to prevent migration must be positioned with the flaps located beyond the obstacle and in the duodenum. If the ostium of the cystic duct is large and is located immediately above the proximal end of the biliary obstacle, it may be useful to select a longer stent to avoid the possibility that it might swing into the cystic duct.

Based on cholangiography, the adequate stent length may be measured using dedicated instruments, such as a graduated guide wire or a guiding catheter that has radiopaque graduations at 1-cm intervals [8,15], or simply by withdrawing a catheter so

Fig. 1 Plastic biliary stents commonly used or found to be superior to other models in randomized controlled trials. a Cotton-Leung stent, made of polyethylene with proximal and distal sideholes and anchoring flaps (Cook Endoscopy, Winston-Salem, North Carolina, USA); b S-shaped stent for drainage of the left biliary tree (Endoflex, Voerde, Germany); c Double-Layer stent with no sideholes and an internal coating made of perfluoroalkoxy material to prevent bacterial adhesion (Olympus, Tokyo, Japan); d Marathon stent with no sideholes and a valve (arrow) designed to prevent reflux of duodenal content into the biliary tree (Cook Endoscopy). Because the valve is pliable, the Marathon stent is only available preloaded on the insertion system, unlike other models.

Stent insertion system. This consists of a plastic guiding cathe-ter equipped with radiopaque markers and a pushing catheter of the same diameter as the stent. These two catheters may be pre-assembled in a single system (single-use or reusable depending on manufacturer); using a pre-assembled system allowed a significant reduction in procedure time as compared with separate guiding and pushing catheters in an RCT [12]. Thin 7.0-Fr stents are inserted over a guide wire without a plastic guiding catheter.

Dilators. Bougies or balloon catheters may be useful in the case of tight strictures.
that its tip moves from the desired location for the upper end of the stent down to the papilla, and using a rule to measure the length of catheter taken out of the endoscope. Estimates using X-ray images are often inaccurate even after adjusting for radiographic magnification, particularly if some parts of the duct to be stented are located in different planes (e.g., with hilar strictures) [15].

Biliary sphincterotomy is not necessary for inserting a single plastic biliary stent or SEMS [16–20]. It is nevertheless routinely performed before stenting by some endoscopists because they think that this will facilitate stent exchange during follow-up, or if more than one biliary stent is to be placed (e.g., because of hilar obstruction or benign biliary stricture). If endoscopic biliary sphincterotomy is performed, blended rather than pure-cut current should be used as this decreases the incidence of bleeding without affecting the incidence of pancreatitis following endoscopic retrograde cholangiopancreatography (ERCP) [21, 22].

If the stricture is tight, dilation of the stricture before stenting may be useful (in case of doubt, a bougie of diameter equal to or greater than that of the intended stent may be inserted through the stricture).

The stent is loaded the right way up onto the guiding catheter, the guiding catheter is flushed with saline, the guide wire is cleaned and moistened to reduce friction, and the whole stent insertion system (guiding catheter, stent, and pusher tube) is introduced into the working channel of the endoscope. Once inserted beyond the biliary obstacle, the guiding catheter is disconnected from the pusher tube by the assistant and the stent is progressively inserted by repeating the following maneuver: 1–2 cm of the stent is pushed out of the duodenoscope (elevator in “low” position); the elevator is closed while the assistant tightens the guiding catheter by moving apart the ends of the guiding catheter and of the pusher tube. Anticlockwise rotation and pulling of the endoscope may be helpful. During the whole procedure, the endoscope is kept close to the papilla to avoid looping of the insertion system in the duodenum. If the plastic guiding catheter is inadvertently withdrawn from inside the stent, it can be reinserted over the guide wire and stent insertion can then be continued.

If stent insertion is difficult, the duodenoscope may be placed in a “long position” and, while it is pulled back with anticlockwise rotation to straighten loops (elevator in “up” position), the guiding catheter is straightened by the assistant to advance the stent. If the stent kinks, it may be necessary to withdraw it and to insert a new one (the guide wire may be left in place by removing the stent “over-the-wire”, using a Soehendra stent retriever or a dilation balloon inflated inside the stent). Once the stent is thought to be in the correct position, the guide wire and the guiding catheter are withdrawn while the pusher tube is held in contact with the stent to prevent stent dislocation. An X-ray is obtained to verify that contrast medium drains through the stent. If the cystic duct is dilated, it is important to check that the upper end of the stent has not turned into that duct.

Plastic stents that are too long may be trimmed using the metal sheath of a mechanical lithotripter loaded with a snare wire. This might be done, for example, where there are multiple plastic stents and removal of the mispositioned stent could dislodge the others (Fig. 2) [23].

Fig. 2 Trimming a plastic biliary stent. The stent is grasped using a snare loaded into the metal sheath of a mechanical lithotripter. (A standard polypectomy snare has been dismantled by removing the wire from the plastic sheath and separating the wire from the metal tube that is inserted into the snare handle.) The snare is closed around the stent using a lithotripter rotator, in a manner similar to that used when crushing a stone with a Dormia basket.

Specific issues

Stents with a duodenal antireflux valve Some stents have a windsock-shaped tubular valve at the duodenal end that is intended to prolong stent patency. These are available only with a prepared insertion system because the valve is too pliable to permit easy assembly. Stent insertion is similar to that for other stents [5].

Insertion of multiple plastic stents Two methods may be used: previous stents may be left in place and additional ones are inserted at each ERCP (sequential multiple stenting), or all stents may be exchanged at each ERCP. A mixed approach consists of sequential multiple stenting in asymptomatic patients and stent exchange in the case of cholangitis [24, 25]. Several means may be used to facilitate the insertion of multiple stents during ERCP: long stents may be inserted first to decrease the risk of proximal stent migration during further stenting; a dilation balloon may be inflated alongside stents already in place to facilitate further stenting; several guide wires may be inserted upstream from the stricture (a 10-Fr plastic stent may be inserted alongside a 0.025-inch guide wire using a standard therapeutic duodenoscope); or, if the Fusion system (Cook Endoscopy) is used, the guide wire used for stent insertion may be left upstream from the stricture after stent release and serve for insertion of the next stent.

Stent exchange If it is anticipated that deep biliary cannulation will be difficult after stent extraction (e.g., in a patient without prior sphincterotomy), the stent may be cannulated, a guide wire inserted through the stent, and the stent extracted through the duodenoscope using a balloon dilation catheter, a snare or a Soehendra stent retriever (Fig. 3).

Rendezvous procedure If endoscopic attempts at deep biliary cannulation fail and percutaneous biliary drainage is performed, a guide wire may be introduced through the percutaneous biliary catheter into the duodenal lumen, where its tip is grasped with an endoscopic snare and pulled back up through the endoscope.
A stent can then be inserted over the guide wire in a standard manner. A percutaneous biliary drain is usually temporarily left above the upper end of the stent, to prevent intraperitoneal leakage of bile in case of immediate stent dysfunction or to prevent obstruction of the stent because of hemobilia.

**Proximal biliary stent migration** This complication may occur during stent insertion or during follow-up. A review of the four largest retrospective case series of proximal biliary stent migration indicates that migrated stents were retrieved at ERCP in 90% of 155 patients [26–29]. Migrated stents were most often retrieved using a grasping basket (36% of cases). Inflation of a balloon extraction catheter alongside or above the stent, cannulation of the stent, or seizing it with a rat-tooth forceps were also used; each of these techniques contributed 15% of successful removals. If the stent has migrated upstream from a stricture, then balloon dilation of the stricture is usually required.

**Self-expandable metal stents**

Compared with their plastic counterparts, self-expandable metal stents (SEMSs) present the advantage of expanding to a much larger diameter than the working channel of the endoscope used for insertion, thus enabling longer patency. After removal of the constraining sheath, a SEMS expands and usually reaches its nominal length and diameter within a few hours or days (the process can be accelerated by inflating a dilation balloon inside the SEMS, but this is not essential for full stent expansion). Disadvantages of SEMSs include their higher cost and that removability is not a standard feature.

**SEMS characteristics**

**Shape and material**

All biliary SEMS are made of metal alloys such as nitinol or Eligiloy; either a mesh is cut from a metal cylinder or metal wires are braided. The main features that differentiate the different types of SEMS are price, shortening ratio, radiopacity, covering, radial force, flexibility, size of the open cells of the mesh, anchoring mechanisms, and design of the ends. SEMS models have undergone considerable development in the last decade: out of five types in use 10 years ago, only a single one is still available [30]. The characteristics of a selection of endoscopic biliary SEMS are summarized in Tables 1 and 2.

In vitro measurements of radial expansion force and of flexibility have shown markedly different results between SEMS, including for covered and uncovered models of otherwise identical SEMS [31]. A high radial expansion force might be preferable, as, with uncovered Wallstents, long-term patency was higher if expansion of the SEMS reached 70% at 24 hours [32]; a high flexibility is particularly important in some locations such as the left intrahepatic ducts (one of the least flexible SEMS is the Wallstent) [31]. During self-expansion, SEMS shorten by 0%–50%; SEMS with a low shortening ratio are preferable in some circumstances (e.g., long SEMS in long tight strictures) but they may be associated with jerky deployment.

Large open cells in the mesh may allow tissue to protrude into the SEMS lumen, making it ineffective for biliary drainage either immediately after insertion or during follow-up [33–35]. Most SEMS have identical mesh cell sizes along their whole length, but some models, designed for hilar strictures, have a section with larger cells in order to facilitate the passage of instruments through the mesh at this point.

The radiopacity of the alloy used for SEMS construction may be high enough to provide adequate radiological visibility along the whole length of the stent (e.g., with the Wallstent); if it is not, radiopaque markers are used to depict SEMS contours but this may be less practical.

With covered SEMS, antimigration mechanisms are particularly important; these may include flared ends or external fins, but the latter frequently cause ulcers of the bile duct wall [36]. The distal end of the SEMS may cause bleeding or perforation if the wires are sharp and not fused (e.g., in the Wallstent); most recent models have soft ends and some have a lasso to facilitate removal of the SEMS.

Most recent nitinol SEMS models are marketed as “magnetic resonance-compatible”; older models made of Eligiloy may also be imaged at magnetic resonance although visualization of the stent lumen may be problematic [37].

**Nominal SEMS size and the delivery catheter**

Most biliary SEMS models are available in several nominal lengths, generally between 4 cm and 10 cm with a nominal diameter of 10 mm, although slimmer or longer models are available from some manufacturers. Biliary SEMS are provided in a constraining sheath, mounted on a delivery catheter that accepts a guide wire measuring up to 0.035 inches in diameter; some models are compatible with short-wire systems. The diameter of the complete assembly ranges between 5.0 Fr (some Leufen stents) and 10.5 Fr (some Shim-Hanaro stents). A thin delivery catheter may be advantageous to facilitate the passage of strictures without prior dilation or for specific purposes such as the simultaneous deployment of two SEMS in the hilum. The diameter of the delivery catheter is larger for the covered model of a SEMS.
Table 1  Selection of biliary uncovered self-expandable metal stents (SEMSs) for endoscopic insertion.

<table>
<thead>
<tr>
<th>Material</th>
<th>Bonastent</th>
<th>Aixstent (Braided)</th>
<th>Aixstent (Laser cut)</th>
<th>Nitinella Plus</th>
<th>Niti-S D-type</th>
<th>Niti-S S-type</th>
<th>Wallflex</th>
<th>Zilver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>Braided, single wire</td>
<td>Braided, single wire</td>
<td>Laser cut</td>
<td>Braided, single wire</td>
<td>Braided, multiple wires</td>
<td>Braided, single wire</td>
<td>Braided, multiple wires</td>
<td>Laser cut</td>
</tr>
<tr>
<td>Diameter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery catheter</td>
<td>7 Fr 10 mm</td>
<td>8.5 Fr 8 or 10 mm</td>
<td>5 Fr or 8.5 Fr 8 or 10 mm</td>
<td>7 Fr 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>7 Fr 6, 8 or 10 mm</td>
<td>8 Fr 8 or 10 mm</td>
<td>6 Fr* or 7 Fr 6, 8 or 10 mm</td>
</tr>
<tr>
<td>Deployed stent</td>
<td>40, 50, 60, 80, or 100, 120 mm</td>
<td>40, 60, or 80 mm</td>
<td>40, 60, 80, 100, or 120 mm</td>
<td>40, 60, 80, or 100 mm</td>
<td>40, 50, 60, 70, 80, 100 or 120 mm</td>
<td>40, 50, 60, 70, 80, 100 or 120 mm</td>
<td>40, 60, 80 or 100 mm</td>
<td>40, 60 or 80 mm</td>
</tr>
<tr>
<td>Shortening ratio†</td>
<td>30 %</td>
<td>20 %</td>
<td>0</td>
<td>27 %</td>
<td>26 %</td>
<td>37 %</td>
<td>45 %</td>
<td>0</td>
</tr>
<tr>
<td>Size of cells</td>
<td>2 × 2 mm</td>
<td>2 mm</td>
<td>5 mm</td>
<td>2.5 × 3 mm</td>
<td>3 × 4 mm</td>
<td>3 × 4 mm</td>
<td>1.7 × 2.7 mm</td>
<td>2.8 × 5 mm</td>
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<td>Markers</td>
<td>Markers</td>
<td>Markers</td>
<td>Markers</td>
<td>Markers</td>
<td>Markers</td>
<td>Full-length</td>
<td>Markers</td>
</tr>
<tr>
<td>Shape</td>
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<td>Straight</td>
<td>Straight</td>
<td>Straight</td>
<td>Straight</td>
<td>Straight</td>
<td>Two flanges</td>
<td>Straight</td>
</tr>
<tr>
<td>Stent recapture</td>
<td>Yes, to 76 % of full deployment (red marks)</td>
<td>No</td>
<td>No</td>
<td>Yes, to 50 % of full deployment</td>
<td>No</td>
<td>No</td>
<td>Yes, to 80 % of full deployment (fluoroscopic marks and on handle of delivery system)</td>
<td>No</td>
</tr>
<tr>
<td>Short-wire compatibility</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Nondiscounted price in Germany, €</td>
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<td>690</td>
<td>790</td>
<td>1,459</td>
<td>780</td>
<td>1,150</td>
<td>1,185</td>
<td>975</td>
</tr>
<tr>
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<td>Leufen Medical, Aachen, Germany</td>
<td>Leufen Medical, Aachen, Germany</td>
<td>ELLA-CS, Hradec Kralove, Czech Republic</td>
<td>Taewoong, Seoul, Korea</td>
<td>Taewoong, Seoul, Korea</td>
<td>Boston Scientific, Natick, Massachusetts, USA</td>
<td>Cook Endoscopy, North Carolina, USA</td>
</tr>
</tbody>
</table>

*The only difference between the 6 Fr (Zilver 635) and 7 Fr (Zilver) model is the thinner, opaque, delivery catheter.
†The shortening ratio was calculated on the basis of manufacturers’ data or on actual measurements by authors, for mid-size SEMS, according to the following formula: (length of constrained SEMS – length of fully deployed SEMS)/length of constrained SEMS.
<table>
<thead>
<tr>
<th>Material</th>
<th>Bonastent</th>
<th>Aixstent</th>
<th>Nitinella Plus</th>
<th>Niti-S</th>
<th>ComVi</th>
<th>Wallflex</th>
<th>Wallstent</th>
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<td>Construction</td>
<td>Braided, single wire</td>
<td>Braided, single wire</td>
<td>Braided, single wire</td>
<td>Braided, single wire</td>
<td>Braided, single wire</td>
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<td>Braided, single wire</td>
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<td>8.5 Fr or 10 Fr* 10 mm</td>
<td>9 Fr 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>8.5 Fr 8 or 10 mm</td>
<td>8 Fr 8 or 10 mm</td>
</tr>
<tr>
<td>Delivery catheter</td>
<td>8.5 Fr or 10 Fr* 10 mm</td>
<td>9 Fr 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>8 Fr 6, 8 or 10 mm</td>
<td>8 Fr 8 or 10 mm</td>
<td>8 Fr 8 or 10 mm</td>
</tr>
<tr>
<td>Deployed stent</td>
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<td>40, 60, 80, or 100 mm</td>
<td>40, 60, 80, or 100 mm</td>
<td>40, 50, 60, 70, 80, 100 or 120 mm</td>
<td>40, 50, 60, 70, 80, 100 or 120 mm</td>
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<td>Length after deployment</td>
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<td>Shortening ratio</td>
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<td>27%</td>
<td>35%</td>
<td>25%</td>
<td>45%</td>
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<td>Markers</td>
<td>Markers</td>
<td>Full-length</td>
<td>Full-length</td>
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<tr>
<td>Shape</td>
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<td>Two flanges</td>
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<td>Polyurethane Partly or fully covered</td>
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<td>PTFE Fully covered</td>
<td>Permalume Partly or fully covered</td>
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<td>Polyurethane Partly or fully covered</td>
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<td>PTFE Fully covered</td>
<td>Permalume Partly or fully covered</td>
<td>Permalume Partly covered</td>
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<tr>
<td>Stent recapture</td>
<td>Yes, to 76% of full deployment (red marks)</td>
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<td>Yes, to 50% of full deployment</td>
<td>No</td>
<td>No</td>
<td>Yes, to 80% of full deployment (fluoroscopic marks and on handle of delivery system)</td>
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<tr>
<td>Short-wire compatibility</td>
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<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Distal lasso for stent repositioning</td>
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<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>Boston Scientific, Natick, Massachusetts, USA</td>
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</tr>
</tbody>
</table>

PTFE, polytetrafluoroethylene.
*The 8.5- and 10-Fr delivery catheters are used for partly and fully covered models, respectively.
†The shortening ratio was calculated on the basis on manufacturers’ data or on actual measurements by authors, for amid-size SEMS, according to the following formula: (length of constrained SEMS - length of fully deployed SEMS)/length of constrained SEMS.
compared with the counterpart uncovered model. The stated nominal length should be regarded with caution for SEMSs that have a high shortening ratio (e.g., the Wallflex stent) because if such a SEMS is deployed in a tight stenosis, its actual length will be significantly longer than expected. Most current delivery catheters are sufficiently kink-resistant for easy SEMS delivery; some are transparent and allow endoscopic visualization of the distal SEMS extremity during deployment. The ability to recapture a SEMS into the delivery catheter after partial deployment is useful if the SEMS is deployed too distally.

Stent covering
Stents are covered in order to prevent stent occlusion by tissue ingrowth and to facilitate SEMS removal. The covering may be made of various materials, including silicone, polyurethane, and expanded polytetrafluoroethylene; it may extend over the entire length of the stent (fully covered SEMS), or small areas at the ends may be left uncovered (partly covered SEMS). Some clinicians, mostly from Asia, cover the SEMS themselves, using polyurethane [38]. The removability of the SEMS may be important in patients with benign or malignant strictures [39, 40]. The presence of an intact covering is the most important determinant for the success of SEMS removal [41].

Future development of self-expandable stents
Drug-eluting SEMSs, although common in vascular applications, are not commercially available for biliary use. The concept of local drug delivery is particularly appealing for the treatment of malignant biliary obstruction, as chemotherapeutic agents may be steadily released from a SEMS [42]; a single human trial has shown the feasibility of this technique [43]. Other areas of research that have been tested in animal models include radioactive SEMS and bioabsorbable self-expanding stents [44, 45].

Technique of SEMS insertion
Equipment
As SEMS are provided with a delivery catheter, no other equipment is required apart from a guide wire and, in some cases, dilators.

Methods
The required stent length is assessed in the same way as with plastic stents, except for covered SEMS in patients with the gallbladder in situ: in such cases many authors try to avoid occluding the cystic duct ostium by inserting the stent below the ostium (or by inserting a thin plastic stent into the gallbladder but this latter approach carries a high morbidity rate) [46].

If applicable, the SEMS delivery catheter and the constraining sheath are flushed with saline before the delivery catheter is advanced over the guide wire into the desired location. The SEMS is deployed under fluoroscopic control by pulling back the constraining sheath, with the elevator in the low position. The position of the SEMS is maintained during deployment by pulling on the delivery catheter; it can be adjusted in the distal direction by more traction on the delivery catheter or, in the proximal direction, by recapturing the SEMS inside the constraining sheath (not possible with all SEMS models) and advancing the delivery catheter again. SEMS models with a low shortening ratio may deploy with only limited traction on the constraining sheath and require careful manipulation. After SEMS delivery, the catheter is withdrawn, taking care to not displace the SEMS with the olive at the tip of the catheter.

If the stent has been deployed too proximally, it may be useful to withdraw the delivery catheter while leaving the guide wire in place and to attempt stent repositioning using a balloon or a rat-tooth forceps. If this fails, a second SEMS may be inserted to prolong the first one. If the SEMS is positioned too distally with a large portion protruding into the duodenum, it may be trimmed (using argon plasma coagulation [APC] with specific settings) to prevent the development of duodenal ulcers (Fig. 4) [47].

Specific situations
Drainage of malignant hilar strictures
In malignant hilar strictures, the hepatic sectors or sector to be drained are usually selected before the start of ERCP, based on magnetic resonance imaging (MRI) or computed tomography (CT) scan, with the aim of draining more than 50 % of the liver volume [48]. As an adequate cholangiogram is usually obtained before ERCP, efforts are made to inject contrast medium only into the obstructed ducts that will be drained, for example by injecting contrast medium after the stricture of interest has been passed, or by using contrast-free cannulation techniques [49, 50].

If the insertion of multiple SEMSs is attempted, they can be placed in a “side-by-side” or a “stent-in-stent” (“Y”) configuration; the side-by-side configuration facilitates SEMS revision [30]. In all cases, the following may be useful: to dilate both sides of the hilum using a balloon catheter (usually 6 mm in diameter); to use a long guide wire that is very stiff for stent insertion; to insert the first SEMS in the left lobe (insertion in the right lobe is...
easier); and, for drainage of the right lobe, to select a duct that is relatively straight (usually in the right paramedian sector). In the side-by-side configuration, guide wires are inserted in all of the desired ducts before SEMS delivery. After deployment of the first SEMS, inserting the second delivery system may be difficult due to impaction of the delivery catheter of the second SEMS against the first now-deployed SEMS (in fact, this may even be impossible with some stent designs, in particular with laser cut stents). Strategies to circumvent this difficulty include the following: side-by-side insertion of two delivery catheters followed by simultaneous deployment of both SEMSs (this requires the use of SEMS with delivery catheters ≤ 6 Fr) [Fig. 5] [51]; a rapid SEMS insertion sequence (the delivery catheter of the second SEMS is inserted over the guide wire while the first SEMS is being deployed); having the first SEMS traverse the papilla; or inserting a temporary plastic stent [52].

Both SEMS should be positioned with their distal end in the duodenum, or at the same level in the CBD, to facilitate SEMS revision if needed.

With the stent-in-stent (Y) configuration, the second (right-hand) SEMS is inserted through the mesh of the first (left-hand) SEMS. Strategies to facilitate this procedure include the following: balloon dilation of the right hepatic duct immediately before inserting the left SEMS (to ease “through-the-mesh” cannulation of the right ducts with a hydrophilic guide wire); dilation of the cannulated SEMS mesh by means of a balloon, before inserting the right-hand SEMS; or use of a specific SEMS with a more open mesh [53,54]. Some SEMS models such as the Wallstent do not allow the stent-in-stent configuration. Similar recommendations can be made for bilateral drainage using plastic stents. A reliable method consists of the following: inserting a 0.025-inch and a 0.035-inch guide wire in the right and the left biliary tree, respectively; dilating the right and left bile ducts; and then inserting a 8.5-Fr stent into the left biliary tree (alongside the 0.025-inch guide wire) followed by the insertion of a 10-Fr stent in the right biliary tree.

Combined stenting in malignant biliary and duodenal obstructions Three situations may develop, depending on the relative timing of the occurrence of biliary and duodenal obstructions:

- The duodenal stenosis develops when a biliary stent is already in place (most frequent situation, which may facilitate further biliary stenting [55]). A biliary SEMS is inserted to prevent further need of biliary drainage (unless the biliary stent already in place is a SEMS and is patent), and then the duodenal SEMS is inserted. Biliary SEMS insertion may be performed by the percutaneous route if endoscopic access to the major papilla is not possible.

- Duodenal and biliary stenoses develop simultaneously. Percutaneous biliary SEMS insertion followed by duodenal stenting may be a preferred option. If a fully endoscopic option is selected, then insertion of the duodenoscope into the second portion of the duodenum is attempted immediately after release of the uncovered duodenal SEMS and, in case of failure, again 24–48 hours later (this is to allow for complete SEMS deployment; balloon dilation of duodenal SEMS causes bleeding that may impair biliary cannulation). The mesh cells of the duodenal SEMS that are close to the major papilla may be cut by means of APC, to facilitate biliary cannulation provided there is enough space between the duodenoscope and the SEMS mesh, or they may be moved apart after biliary cannulation, using a balloon catheter [56]; a specific duodenal SEMS with unfixed wires may also be used [57].

- The biliary stenosis develops when a duodenal SEMS is already in place (a rare situation). The techniques described above for inserting a biliary SEMS through the mesh of the duodenal SEMS, using APC or balloon dilation, may be useful if the endoscopic route is chosen.

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