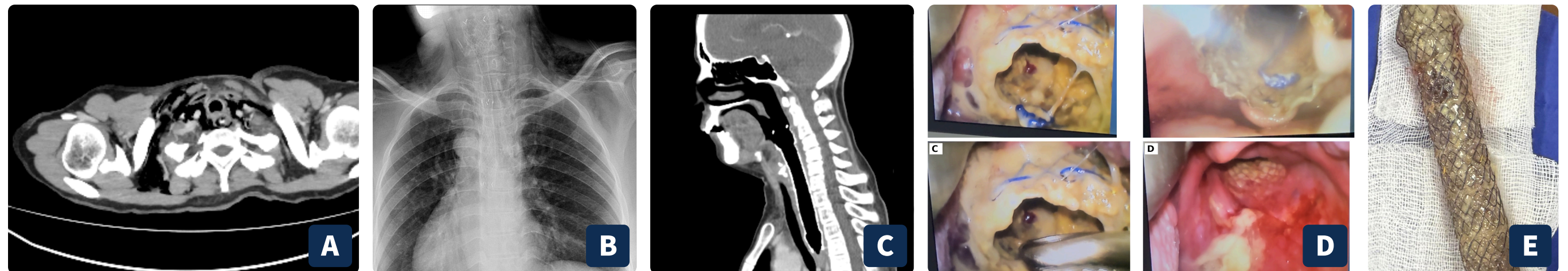


# Proximal Migration of a Fully Covered Oesophageal Stent into the Hypopharynx Causing Life-Threatening Laryngeal Inlet Obstruction

A rare case report

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**A.** CT: surgical emphysema after perforation. **B.** Stent in intended position. **C.** CT 24 h before the crisis: airway patent. **D.** Laryngoscopy: stent across the laryngeal inlet, Magill retrieval, inlet after removal. **E.** Retrieved stent.

## INTRODUCTION

- Fully covered SEMS are preferred when early retrieval is intended, but migrate more often than partially covered stents (25.3% vs 10.9%; up to 40% in benign disease).
- Migration is usually distal. Proximal migration occluding the laryngeal inlet is exceptionally rare; one comparable case reported (Sloan et al.).

## CASE PRESENTATION

**40-year-old woman**, T4a node-positive SCC of the posterior hypopharyngeal wall extending into the cervical oesophagus. Definitive chemoradiotherapy completed Nov 2025; MRI in Feb and May 2026 showed no residual disease. PEG-dependent for nutrition.

- 16 Jun 2026** — endoscopy for PEG removal: tight radiation stricture at 16 cm, impassable even with a paediatric endoscope; iatrogenic perforation with surgical emphysema (A). 18 × 130 mm fully covered SEMS deployed, proximal end at 13 cm, just below the aryepiglottic folds (B). Discharged day 3; retrieval planned at six weeks.
- 18 & 22 Jul** — emergency visits with cough and breathlessness; discharged.
- 23 Jul** — CT: stent in situ, no perforation, airway patent (C). That evening she vomited, then developed acute inspiratory stridor.
- 24 Jul** — oxygen requirement rose from 2 to 15 L/min; loud stridor, no crepitus; CRP 47 → 125 mg/L. Intensive care with hypoxaemic respiratory failure.

## EMERGENCY INTERVENTION

- Difficult airway (irradiated neck, foreign body at the inlet): planned jointly by gastroenterology, anaesthesia and head and neck surgery, ready for a surgical airway.
- Under GA, laryngoscopy confirmed the stent covering the laryngeal inlet (D). It was withdrawn with Magill forceps (E) and the airway secured by intubation, 38 days after insertion.
- Outcome:** extubated on day 2; aspiration pneumonitis settled with antibiotics. By 28 Jul: SpO<sub>2</sub> 97% on 2 L/min, mobilising.

## DISCUSSION

- Risk factors:** benign radiation stricture, fully covered stent, short-term indication (perforation), proximal end near the upper oesophageal sphincter.
- Six days of cough suggest gradual displacement; vomiting may have caused or followed the migration.
- Unlike Sloan et al., whose case resolved on retrieval, our patient needed intensive care and ventilation.

## LEARNING POINTS

- New cough, dyspnoea, stridor or voice change with a cervical stent = migration until proven otherwise.
- A normal CT cannot rule out later migration; bedside fiberoptic laryngoscopy is diagnostic and therapeutic.
- Retrieve with a multidisciplinary team and surgical-airway backup.
- If high cervical stenting is unavoidable: fixation, early planned removal, patient counselling.

**CONCLUSION** Proximal migration of a fully covered oesophageal stent into the hypopharynx is rare but potentially fatal. Suspect it in any patient with a high cervical stent who develops respiratory symptoms, regardless of recent reassuring imaging; early airway visualisation, immediate retrieval and multidisciplinary airway support are life-saving.