Most pharyngeal strictures are treated with dilation, laser ablation or surgery. However, these methods may sometimes be ineffective, expensive or are associated with many complications. Therefore, we need to find a minimally invasive treatment alternative. To our knowledge, the efficacy of steroid injection combined with endoscopic balloon dilation has been verified in various studies [1]. And endoscopic radial incision and cutting has been used to treat patients with esophageal anastomotic strictures [2, 3]. It is unclear whether endoscopic treatment is effective and safe for pharyngeal stricture.

A 34-year-old woman inhaled flames at the age of 2 years. She had experienced choking and aspiration of food and liquids. Endoscopy was performed when she was aged 34 years, revealing a severe pharyngeal stricture with severe scar adhesion and a partial defect of the epiglottis. The pediatric gastroscope was not able to pass through the hypopharynx area. The esophagogram revealed that the stricture was mainly in the hypopharynx, and the length was approximately 3–4 mm (▶Fig. 1).

After a general discussion, we planned to perform the endoscopic cicatricotomy with electrosurgical knives (▶Video 1). First, we inserted a guidewire through the stricture. Next, an endoscope with a transparent cap attached to its tip was engaged to recognize the wall plane of hypopharynx to be incised. We incised the adhesion and scars with an insulation-tipped knife and hook knife until the endoscope was able to pass into the upper esophageal lumen (▶Fig. 2). Finally, we injected a long-acting steroid (10 mL, 50 mg) into the submucosa. There were no immediate or delayed complications. Endoscopic examination 6 months after dissection showed that the diameter of the stricture was 8 mm. Therefore, we performed a second procedure of endoscopic adhesiolysis and cicatricotomy.
and submucosal injection of long-acting steroid. The patient has been visiting the outpatient department for 4 years, and endoscopy has shown no stricture recurrence.

Endoscopy_UCTN_Code_CCL_1AB_2AB

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Competing interests

None

The authors

Xia Xie, Jian-Ying Bai, En Liu, Xue Peng, Feng-Yu Xiao, Shi-Ming Yang, Chao-Qiang Fan
Department of Gastroenterology, Xinqiao Hospital, Army Military Medical University, Chongqing, China

Corresponding author

Chao-Qiang Fan, MM
Department of Gastroenterology, Xinqiao Hospital, Army Military Medical University, Chongqing 400037, China
Fax: +86-023-68774004
fcqxhkwjss@126.com

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