A 19-year-old man was referred to our unit with a 5-year history of dysphagia and food impaction. Upper endoscopy revealed a concentric stricture in the proximal esophagus, which underwent subsequent balloon dilation to 15 mm. Strikingly, a well-established mucosal septum was identified below the stricture, forming a double-lumen esophagus (DLE) that partially obstructed the esophagus (Fig. 1). Biopsies from the mid and distal esophagus revealed inflammation, and high dose proton pump inhibitors were started.

The patient continued to experience dysphagia and intervention was therefore planned (Video 1). A gastroscope (GIF-HQ290; Olympus, Tokyo, Japan) was introduced under general anesthetic. The proximal stricture was balloon dilated to 15 mm. Indigo carmine dye was injected into the proximal end of the duplicate lumen to check patency as the dye flowed distally onto the main lumen. An SB-knife (Sumitomo Bakelite Co. Ltd., Tokyo, Japan) was used to divide the septum (ERBE VIO 200D, Endocut I, Effect 1, Duration 3, Interval 3; Erbe Elektromedizin GmbH, Tübingen, Germany). The septectomy was performed from the proximal to the distal orifice without complications (Fig. 2). The patient’s symptoms drastically improved after the procedure. Further biopsies were taken and confirmed eosinophilic esophagitis (EoE), and a 6-week course of fluticasone oral slurry was started. After 2 years of follow-up, he remains asymptomatic with no further interventions required (Fig. 3).

EoE is a chronic immune condition presenting with symptoms of dysphagia or food impaction. Stricture development is the main indication for endoscopic treatment [1]. The DLE is a rare endoscopic finding, previously reported as a complication to nasogastric tube insertion [2] or associated with other uncommon conditions (i.e. esophagitis disse- cans superficialis) [3]. To our knowledge, this is the first report of an EoE and DLE association and its successful management by endoscopic septectomy and balloon dilation.

Competing interests

Krish Ragunath is a consultant for Olympus and has received research and educational grants from Olympus and Pentax. He received educational grant from ERBE.
The authors

Jose Santiago Garcia1, John Duffy2, Jacobo Ortiz-Fernandez-Sordo1, Shivkumar Budihal2, Adolfo Parra-Blanco2, Krish Ragunath2

1 Puerta de Hierro University Hospital of Majadahonda, Majadahonda, Spain
2 NIHR Nottingham Digestive Diseases Biomedical Research Centre, Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom

Corresponding author

Krish Ragunath, MD
NIHR Nottingham Digestive Diseases Biomedical Research Centre, Nottingham University Hospitals NHS Trust, Queens Medical Centre Campus, E Floor, West Block, Derby Road, Nottingham, NG7 2UH, United Kingdom
Fax: +44-115-9691169
K.Ragunath@nottingham.ac.uk

References


Bibliography

DOI: https://doi.org/10.1055/a-1119-0894
Published online: 2020
Endoscopy
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Fig. 2 Septectomy. a An antegrade septectomy was performed starting at the proximal end. An SB-knife (Sumitomo Bakelite Co. Ltd., Tokyo, Japan) was chosen to carry out the procedure. b Final appearances of the esophagus.

Fig. 3 Follow-up endoscopy 4 weeks after showing complete resolution of the septum.