Endoscopic ultrasound-guided recanalization of complete pharyngoesophageal stenosis

A 74-year-old man was referred because of complete esophageal obstruction. He had a diagnosis of T3N1 hypopharyngeal squamous cell carcinoma and had undergone chemoradiotherapy with a complete response. He had a percutaneous endoscopic gastrostomy (PEG) for nutrition and had had aphagia for 18 months. Assessment of the stricture using contrast swallow demonstrated complete esophageal obstruction (▶Fig. 1), and combined anterograde (peroral) and retrograde endoscopy (through the feeding gastrostomy tract) revealed complete esophageal obstruction at the level of the upper esophageal sphincter (▶Fig. 2, ▶Fig. 3). An attempt at rendezvous was unsuccessful [1]. We decided to perform the procedure guided by endoscopic ultrasound (EUS) (▶Video 1). Through the PEG, a guidewire was advanced into the upper esophagus and an endoscopic retrograde cholangiopancreatography (ERCP) extractor balloon inserted over the guidewire. The balloon was filled with contrast to give a visible target on EUS. However, the balloon was not adequately identified with
the echoendoscope positioned in the hypopharynx. On fluoroscopy, a separation between the balloon and the echoendoscope was observed, by which contrast was introduced through the lumen of the balloon. EUS now showed a good target in the esophageal lumen. With a 19-G needle, the esophageal lumen was punctured and a 0.025-inch Visiglide guidewire advanced. The echoendoscope was removed, and adequate positioning of the guidewire was verified with a gastroscope (▶Fig. 4). A 6-Fr cystotome and a 6-mm dilation balloon were used to create a passage, followed by placement of a 12-Fr jejunal probe to keep the passage patent.

After 7 days, regular dilation sessions were started with Savary bougienage to 16-mm in diameter. In two of the sessions, mitomycin was injected at the level of the stenosis. After 13 dilations, adequate tolerance of a normal diet was achieved and the PEG was withdrawn. At 3 years' follow-up, no recurrence of stenosis was seen.

Endoscopy_UCTN_Code_TTT_1AO_2AH

Competing interests

Dr. J. R. Aparicio is a consultant for Boston Scientific.

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Endoscopy
DOI 10.1055/a-1270-6704
ISSN 0013-726X
published online 2020
© 2020, Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany