Bidirectional recanalization of a complete postradiation stricture of the hypopharynx and esophagus.

A 65-year-old patient was referred for endoscopic management of a complete radiation-induced stricture, 5 cm in length, of the hypopharynx and esophagus (▶Fig. 1, ▶Video 1). He had a history of curative chemoradiation therapy for T2N1 squamous cell carcinoma of the larynx. His nutrition was exclusively maintained through a percutaneous gastrostomy. Recanalization of the esophagus was considered after a multidisciplinary discussion, as previously described [1–3].

The percutaneous gastrostomy site was reinforced by providing endoscopic gastropexy to the abdominal wall with four sutures using a double-needle device (Freka Pexact; Fresenius Kabi Ltd, Run- corn, UK). The gastrostomy site was bougie-dilated to 14 mm and a 9-mm endoscope was inserted. A mixture of hydroxyethyl starch and indigo carmine was injected and the fibrotic tissue was dissected with a 1.5-mm Dual Knife (Olympus, Tokyo, Japan) (▶Fig. 2). Step by step a new lumen was created up to the level of the hypopharynx. At this level, a perorally introduced gastroscope was able to discern transillumination and an endoscopic rendezvous was achieved (▶Fig. 3). At the end of the procedure, the proximal orifice was sufficiently dissected up to 10 mm (▶Fig. 4, ▶Fig. 5). The patient was admitted for 48 hours for observa-
tion and discharged uneventfully. No stent was placed due to the risk of intolerance and/or creation of a fistula [3]. At 5 months of follow-up, the patient underwent serial endoscopic balloon dilations up to 20 mm to keep the tunneled stricture patent. In conclusion, complete postradiation strictures of the esophagus and hypopharynx could be managed by bidirectional dissection of the fibrotic tissue. Although technically challenging, this procedure may spare the need for more invasive and morbid surgery. The addition of gastropexy prior to the main procedure and the bidirectional approach of recanalization are the two elements that differentiate our approach from previously published case reports.

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AD

Competing interests

The authors declare that they have no conflict of interest.

The authors

Georgios Mavrogenis1, Fateh Bazerbachi2, Konstantinos Markoglou1, Sandro Porceddu1, Sunil Gupta4, Luke Hourigan4
1 Unit of Hybrid Interventional Endoscopy, Department of Gastroenterology, Mediterraneo Hospital, Athens, Greece
2 Department of Gastroenterology, CentraCare, St. Cloud, Minnesota, USA
3 Department of Oncology, Brisbane’s Princess Alexandra Hospital, Brisbane, Australia
4 Department of Gastroenterology, Brisbane’s Princess Alexandra Hospital, Brisbane, Australia

Corresponding author

Georgios Mavrogenis, MD
Unit of Hybrid Interventional Endoscopy, Department of Gastroenterology, Mediterraneo Hospital, Ilias 12, Glyfada 16675 Athens, Greece
mavrogenis@gmail.com

References


Bibliography

Endoscopy 2022; 54: E709–E710
DOI 10.1055/a-1753-9450
ISSN 0013-726X
published online 28.2.2022
© 2022. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany