A 71-year-old man was referred to our department with a post-esophagectomy anastomotic atresia. Nine months previously, he had undergone transhiatal esophagectomy for esophageal intramucosal squamous carcinoma. Frustratingly, he developed a serious post-esophagectomy stenosis. Several esophageal bouginage and stent procedures failed to stop the progressive stenosis. Finally, a jejunal nutrition tube was placed for feeding, piercing the epigastric skin. After the large amount of retained fluid had been suctioned, the upper esophagus appeared to be blocked and a guidewire could not be advanced under esophagogastroduodenoscopy guidance (▶Fig. 1). Endoscopic ultrasound-guided fine-needle aspiration (EUS-FNA) was performed to reconnect the esophagus and stomach (▶Fig. 2a). Reverse-direction transnasal gastroscopy from the jejunal fistula and digital subtraction angiography were used to monitor the process (▶Fig. 2b). A zebra guidewire was then placed into the channel to guide the subsequent dilation with a cystotome and placement of a stent. After removing the stent 2 months later without complications, the reopening of the esophageal lumen was confirmed to have been successful (▶Fig. 3). All the procedures are shown in ▶Video 1.

Anastomotic atresia developing from severe post-esophagectomy stricture has not been reported previously [1, 2]. This case presents a novel way of re-establishing the digestive tract lumen under EUS guidance for anastomotic atresia, suggesting that EUS-FNA could play a greater role in the interventional therapy of digestive tract atresia [3].

Competing interests

The authors declare that they have no conflict of interest.
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References


Video 1 Re-establishment of the digestive lumen in a post-esophagectomy anastomotic atresia. Up to three monitors including endoscopic ultrasound, digital subtraction angiography, and reverse-direction transnasal gastroscopy from the jejunal fistula were used to supervise and guide the whole procedure.