

A “tuft” procedure

A 53-year-old man presented with dysphagia for solid food. He had a history of esophageal atresia that had required repair with a colonic interposition as a child. In 2008, he had presented with dysphagia, dyspnea, and a bulge in his neck. Computed tomography (CT) scanning showed herniation of the colonic conduit into his neck with ischemic changes. He had undergone emergency resection of the conduit and esophagogastric reconstruction, which was complicated by a tight anastomotic stricture that had been managed with esophageal dilation and stenting for 3 years. Unfortunately, a large anterior esophagocutaneous fistula had developed in his chest wall, which required repair in 2012 with a pectoralis major musculocutaneous skin flap to reconstruct his cervical esophagus. He was subsequently referred for endoscopy because of recurrence of his dysphagia.

At upper gastrointestinal endoscopy, a benign anastomotic stricture was found at 28 cm from the incisors. Serial dilation was performed up to 36 Fr. Interestingly, hair was found growing in the cervical esophagus from the musculocutaneous skin flap (● Fig. 1).

Esophageal hair growth is a rare endoscopic finding that occurs after cutaneous skin grafting to reconstruct the cervical

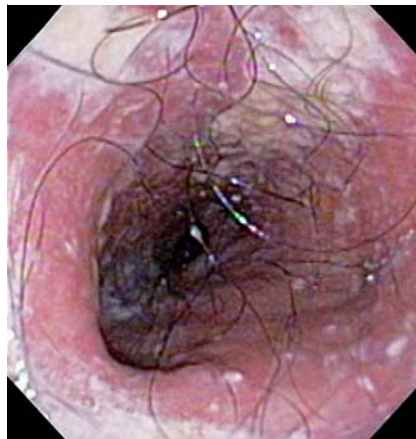


Fig. 1 Endoscopic image of the cervical esophagus showing luminal hair growth and a distal anastomotic stricture.

esophagus, typically after oncologic resection for oropharyngeal cancers [1–4]. Although hair growth can be extensive enough to cause dysphagia and necessitate endoscopic “haircuts”, the severe anastomotic stricture was more likely to have been the cause of the dysphagia in our patient.

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Competing interests: None

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