A 31-year-old man with an allergic constitution who had previously undergone endoscopic removal of impacted food in 2008 was referred to the outpatient clinic for chronic intermittent dysphagia of solid food. An upper endoscopy performed after administration of high-dose proton pump inhibitors showed linear furrows. Examination of mid and proximal esophageal biopsy specimens showed mild basal hyperplasia, moderate spongiosis, and a peak of 120 intraepithelial eosinophils per high power field (Fig. 1). The patient was diagnosed with eosinophilic esophagitis [1]. The patient showed a partial response to swallowed fluticasone aerosol and subsequently to budesonide, and was referred to the outpatient clinic of our hospital.

Pending his appointment, the patient presented himself to the referring hospital with acute impaction of a piece of beef. Emergency endoscopy (performed without sedation) revealed an impacted food bolus in the distal esophagus (Fig. 2a). During the procedure the patient vomited violently, but the pressure failed to mobilize the food bolus. The bolus was removed using a snare and Roth Net retriever (US Endoscopy, Mentor, Ohio, USA). After bolus removal, the patient experienced progressive epigastric pain, and a perforation was seen at 38 cm from the dental arcade (Fig. 2b). A partially covered self-expandable metal Wallflex stent (diameter 18 mm, length 100 mm, 70 mm covered; Boston Scientific, Natick, Massachusetts, USA) was placed and a double-lumen duodenal feeding probe was introduced. A chest radiograph demonstrated free mediastinal and upper abdominal air and the position of the stent in situ (Fig. 3a). The patient received analgesics and antibiotics. An esophagogram performed 4 days after perforation showed no leakage of contrast, and the patient was discharged.

Stent removal was performed 3 weeks later at our hospital. The proximal esophagus demonstrated linear furrows and white exudates (Fig. 2c). Unfortunately, stent removal was hindered by tissue ingrowth in the uncovered proximal part of the stent (Fig. 2d), and a fully covered Niti-S stent-in-stent was placed (diameter 18 mm, length 60 mm; Taewoong Medical, Seoul, Korea) (Fig. 3b). After 1 week, the Niti-S stent was easily removed (Fig. 2e); however, removal of the Wallflex stent required gentle back and forth manipulation (Fig. 2f). The esophageal perforation had healed.
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Fig. 2 Endoscopic procedures performed after food bolus impaction. a Impacted food bolus in the distal esophagus. b Esophageal perforation following the removal of the impacted food bolus. c Linear furrows and white exudates in the proximal esophagus. d Tissue ingrowth in the uncovered proximal section of the stent hindered its removal. e The stent-in-stent Niti-S stent was removed easily 1 week later. f Removal of the initial stent was eventually achieved by gentle back and forth manipulation.

Fig. 3 Radiographic images. a Free upper abdominal air (large arrows) and the stent (small arrows) after perforation. b Niti-S stent positioned inside the proximal, uncovered part of the Wallflex stent.