Endoscopic vacuum therapy for esophageal perforations and leakages

Introduction

Injuries to the esophageal wall, such as perforations and anastomotic leaks, are serious complications of surgical and endoscopic interventions. Since 2006, a new treatment has been introduced, in the form of endoscopically placed vacuum sponge therapy.

Patients and methods

Between April 2012 and October 2014, 10 patients (5 men and 5 women) aged 57–94 years were treated at our institution using endoscopic vacuum therapy (EVT) in the upper gastrointestinal tract with pararectal abscesses due to anastomotic insufficiencies after rectal surgery. It involves placing an open-core sponge in the abscess cavity, connected to a drainage tube with a negative-pressure pump [9,10]. In recent years, this approach has also been adapted for use in the upper gastrointestinal tract and it is used as an alternative in the treatment of patients with upper gastrointestinal perforations or leakages.

Only very few institutions have published reports on their experience with this new technique to date.

Results

The defect in the esophageal wall was successfully closed in seven of the 10 patients (70%). No severe complications occurred.

Conclusions

EVT is a valuable tool for management of defects in the esophageal wall and should be considered as a treatment option for patients with this condition.

Bibliography

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large mediastinal cavity had to be achieved using balloon dilation of the small opening before sponge placement.

### Technique of sponge placement

The commercially available EndoSponge® system (B. Braun Melsungen Ltd., Melsungen, Germany) was used in all patients. The system consists of an overtube, which is placed into the cavity or in the esophageal lumen after intubation with the endoscope. After the endoscope has been removed, the small sponge is positioned in the cavity using a pusher device over the overtube. Correct placement is checked endoscopically after removal of the overtube, and suction is applied with a negative-pressure pump (InfoV.A. C®, Kinetic Concepts Inc., San Antonio, Texas, USA) after overtube, and suction is applied with a negative-pressure pump.

Placement of the sponge and sponge changes were performed every 3 to 5 days.

Enteral nutrition was ensured with a percutaneous endoscopic gastrostomy (PEG) catheter in three patients and with transnasal enteral feeding tubes in seven patients. All of the conscious patients were able to drink, and patients with extraluminal sponge placement were able to eat soft food.

### Results

The defect in the esophageal wall was successfully closed in seven of the 10 patients (70%). One patient died due to fulminant sepsis during the treatment. The time between perforation or detection of an anastomotic insufficiency and the start of vacuum therapy was less than 24 hours in four patients. The time between detection and intervention was more than 14 days in two patients. The median treatment time was 5 days in patients with endoluminal sponge placement and 14 days in patients with extraluminal sponge placement. The median hospitalization time was 38 days. The median follow-up period was 4 months. Two patients died of stroke with respiratory insufficiency not related to the sponge treatment, 3 and 6 weeks, respectively, after successful closure of the esophageal defects.

### Patients with failed closure

In the first patient with failed closure of a large anastomotic insufficiency after thoracoabdominal resection of the esophagus, vacuum therapy was started after two failed courses of treatment.

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**Table 1** Data on patients.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Location of perforation or esophageal insufficiency</th>
<th>Cause</th>
<th>Location of sponge</th>
<th>Duration of treatment</th>
<th>No. of sponge exchanges</th>
<th>Sedation vs. anesthesia</th>
<th>Time from detection to start of treatment</th>
<th>Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>64 Esophagus 32 cm</td>
<td>Anastomotic insufficiency after thoracoabdominal resection of the esophagus</td>
<td>Extraluminal</td>
<td>5 months</td>
<td>39</td>
<td>Anesthesia</td>
<td>&gt;24h (12 weeks)</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>83 Esophagus 16 cm</td>
<td>Iatrogenic endoscopic perforation</td>
<td>Extraluminal</td>
<td>5 days</td>
<td>0</td>
<td>Anesthesia</td>
<td>&lt;24h</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>87 Esophagus 17 cm</td>
<td>Anastomotic insufficiency after thoracoabdominal resection of the esophagus</td>
<td>Extraluminal</td>
<td>4 days</td>
<td>1</td>
<td>Anesthesia</td>
<td>&gt;24h</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>72 Piriform recess/proximal esophagus</td>
<td>Iatrogenic perforation after removal of a foreign body (dental prosthesis)</td>
<td>Extraluminal</td>
<td>5 days</td>
<td>0</td>
<td>Anesthesia</td>
<td>20h</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>65 Esophagus 28 cm</td>
<td>Anastomotic insufficiency after thoracoabdominal resection of the esophagus</td>
<td>Extraluminal</td>
<td>12 days</td>
<td>2</td>
<td>Sedation</td>
<td>&gt;24h</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>57 Esophagus 22 cm</td>
<td>Perforation by a foreign body (peach pit)</td>
<td>Extraluminal</td>
<td>26 days</td>
<td>6</td>
<td>Anesthesia</td>
<td>&gt;24h</td>
<td>Yes</td>
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<tr>
<td>7</td>
<td>Female</td>
<td>77 Piriform recess/proximal esophagus</td>
<td>Iatrogenic perforation during intubation</td>
<td>Extraluminal</td>
<td>5 days</td>
<td>0</td>
<td>Anesthesia</td>
<td>&gt;24h</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>76 Esophagus 33 cm</td>
<td>Anastomotic insufficiency after thoracoabdominal resection of the esophagus</td>
<td>Extraluminal</td>
<td>4 days</td>
<td>0</td>
<td>Sedation</td>
<td>&lt;24h</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Male</td>
<td>64 Esophagus 28 cm</td>
<td>Anastomotic insufficiency after thoracoabdominal resection of the esophagus</td>
<td>Extraluminal</td>
<td>1 day</td>
<td>0</td>
<td>Sedation</td>
<td>&lt;24h</td>
<td>No; surgical closure of the leak</td>
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<td>10</td>
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<td>94 Esophagus 20 cm</td>
<td>Iatrogenic endoscopic perforation</td>
<td>Extraluminal</td>
<td>24 days</td>
<td>4</td>
<td>Anesthesia</td>
<td>&gt;24h (16 days)</td>
<td>Yes</td>
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</table>
with fully covered metal stents. The wall of the abscess cavity was therefore consolidated, and it was not possible to stimulate granulation tissue through the sponge treatment. The patient also developed increasing numbers of fistulas between the abscess cavity and the peripheral bronchial airways. After a large number of sponge exchanges (n = 39), the patient died due to complications after a surgical rescue intervention.

The second patient died of fulminant sepsis, which had commenced already before the first sponge placement. The third patient with failed sponge treatment underwent surgery early after the sponge placement, because of the development of a large pleural empyema causing sepsis. The esophagus was removed, and a cervical esophagostomy was created. The patient is awaiting a colon interposition.

Side effects and complications

All of the interventions were performed without severe side effects besides the three failed treatments mentioned above. The sponge ruptured during removal procedures in two patients. The residual parts of the sponges were easily extracted using a rat-tooth forceps, with no damage to the surrounding structures. In one patient, an esophageal stenosis in the area of the prior sponge therapy had to be dilated using bougies. One patient with a very proximal perforation (no.4) developed respiratory-associated pneumonia during the course of treatment, due to artificial ventilation required for 5 days.

Discussion

The main causes of defects developing in the esophageal wall are anastomotic insufficiencies and iatrogenic perforations after endoscopic interventions such as endoscopic submucosal dissection or dilation. Other conditions, such as a perforation by a foreign body or spontaneous rupture of the esophagus (Boerhaave syndrome), only account for a small number of cases. Minimally invasive treatment options include clipping with standard or over-the-scope clips, and placement of metal or plastic stents. However, clips are limited to perforations up to 25 mm long [5], and stent placement is associated with the risks of stent migration, pain and discomfort, hemorrhage, tissue ingrowth, and food obstruction [11, 12].

Surgical repair with suturing of defects, with or without interposition of muscle flaps or esophagectomy, was the treatment of choice for many years in patients with defects of the esophageal wall. It is accompanied by a mortality rate of 10% to 12% [13, 14]. Due to the bacterial contamination of the mediastinum and the development of septic conditions, the mortality rate in patients in whom the start of treatment is delayed by >24 hours reaches 20%, in comparison with 7% in patients in whom treatment starts earlier [14]. In our group of patients we discovered a mortality of 20% during treatment (patients No. 1 and 3). In both patients the treatment started after more than 24 hours, in patient No. 1, after 5 months. No death occurred in the group of patients who started treatment within 24 hours.

Cleansing of the contaminated mediastinum is one of the key points in treating esophageal perforations, and mediastinal abscesses and stent therapy should therefore be combined with mediastinal drainage in all cases in which there are detectable mediastinal abscesses. In the present group of patients, the start of therapy was >24 hours in six patients, and two of the three patients with treatment failure belonged to this group.

A major advantage of vacuum therapy is the ability to cleanse the perforation cavity using a minimally invasive approach; this is required in order to avoid sepsis and death. In the present study, it was possible to cleanse even consolidated wound cavities, with walls covered with fibrous tissue, to produce fresh granulation tissue during the first 3 to 5 days of vacuum-assisted treatment (Fig. 1 – 5). This effect has been well known since the first endoscopic lesions were treated with vacuum therapy in the rectum [15]. The effectiveness of sponge cleansing has also led to its use in infected pancreatic pseudocysts in two cases, with good resolution of the cavities [16, 17].

A few other types of lesions outside of the esophagus and rectum have also been treated successfully with this method, such as anastomotic insufficiencies in the stomach [18], after pancreatecoduodenectomy [19], in patients with Boerhaave syndrome [20], after duodenal perforation [21] and after bariatric surgery with gastric Roux-Y-bypass [22] (Table 2). A special feature of the present study is that a high proportion of the patients (70%) were suffering from leakages in the proximal part of the esophagus; in two patients, the perforation tear had even reached the piriform recess.

The complexity of perforations in the proximal esophagus is greater than in the distal esophagus, because surgery is much more invasive and stent placement involves the risk of impairing the airway. In the present group of patients, management of the airway in patients with very proximally located perforations (patients 4 and 7, Table 1) was only achieved using general anesthesia during the whole course of treatment, for 5 days. This strategy is accompanied by a risk of the development of respiratory-associated pneumonia, as was observed in patient no.4. In other patients, it was possible to carry out sponge changes only under general anesthesia, due to the proximity of the lesions to the airway.

This and the fact that placement of the sponge requires a high degree of endoscopic skill indicates that endoscopic vacuum therapy should only be performed in high-volume centers with expertise in interventional endoscopy and intensive-care medicine. Treatment decisions should be made by an interdisciplinary team including visceral surgeons, radiologists, and endoscopists in order to discuss the different treatment options.

The major disadvantage in evaluating this promising new technique is the absence of comparative studies, due to the complexity of the subject and the large number of different treatment options possible – such as various types of surgical interventions and different types of stent and clip devices. Therefore it is not possible to recommend this new method as first-line treatment in management of all leaks and perforations of the esophagus.

Brangewitz et al. reported on a retrospective comparative study including 32 patients who received EVT and 39 patients who underwent stent treatment, with mortality rates of 15% and 25%, respectively [23]. The other comparative study available (Schneewind et al.) compared the outcomes of patients with postsurgical esophageal defects and systemic inflammation and reported statistically significant differences in the mortality rates among patients with surgical repair, stent placement, or endoscopic vacuum therapy: 50%, 83%, and 12%, respectively [24]. A limitation of this study is its retrospective data collection without randomization of the patients.

Limitations of the present study include the small sample size of 10 patients, differences in the underlying causes of the esophageal wall defects, and a lack of comparison with other treatment modalities. A large-scale multicenter study would be mandatory.
in order to overcome these limitations, because the occurrence of esophageal perforations and leaks is fortunately a rare event. EVT for defects in the esophageal wall is a valuable tool in the management of this high-mortality condition and should be taken into consideration by surgeons and gastroenterologists when discussing treatment options in these patients. Prospective and comparative studies are required in order to further evaluate the significance of this new minimally invasive approach.

Table 2  Current literature.

<table>
<thead>
<tr>
<th>Author</th>
<th>Journal</th>
<th>Title</th>
<th>No. of patients</th>
</tr>
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<tbody>
<tr>
<td>Loske G; Müller C.</td>
<td>Zentralblatt für Chirurgie 2009; 134: 267–270</td>
<td>Vakuumtherapie einer Anastomoseninsuffizienz am Osophagus–ein Fallbericht</td>
<td>1</td>
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<tr>
<td>Loske G, Schorsch T, Mueller CT</td>
<td>Endoscopy 2010; 42 Suppl 2: E109</td>
<td>Endoscopic intraluminal vacuum therapy of duodenal perforation</td>
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<tr>
<td>Loske G, Schorsch T, Müller C</td>
<td>Surgical endoscopy 2010; 24: 2531–2535</td>
<td>Endoscopic vacuum sponge therapy for esophageal defects</td>
<td>10</td>
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<tr>
<td>Schniewind B, Schafmayer C, Both M et al.</td>
<td>Endoscopy 2011; 43 Suppl 2 UCTN: E64–65</td>
<td>Ingrowth and device disintegration in an intralobar abscess cavity during endoscope therapy for esophageal anastomotic leakage</td>
<td>1</td>
</tr>
<tr>
<td>Wallstabe I, Tiedemann A, Schiefke I</td>
<td>Endoscopy 2011; 43 Suppl 2 UCTN: E312–314</td>
<td>Endoscopic vacuum-assisted therapy of an infected pancreatic pseudocyst</td>
<td>1</td>
</tr>
<tr>
<td>Wallstabe I, Tiedemann A, Schiefke I</td>
<td>Endoscopy 2012; 44 Suppl 2 UCTN: E49–50</td>
<td>Endoscopic vacuum-assisted therapy of infected pancreatic pseudocyst using a coated sponge</td>
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</table>
Competing interests: None

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