

Spontaneous perforation of an intramural esophageal pseudodiverticulosis treated with intraluminal endoscopic vacuum therapy using a double-lumen vacuum drainage with intestinal feeding tube

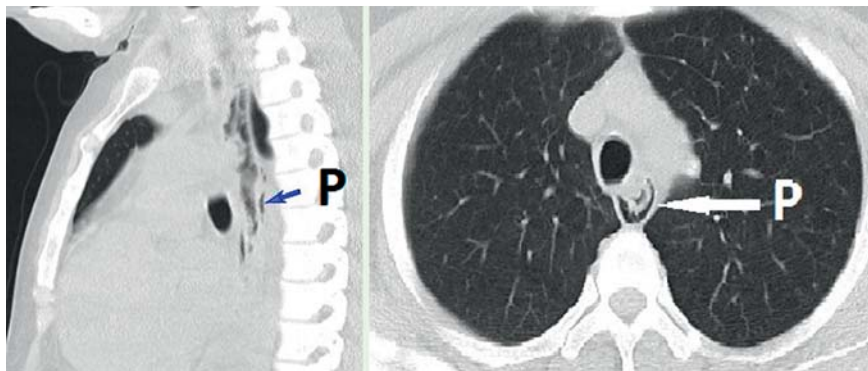


Fig. 1 Thoracic computed tomography showing perforation (P) of the esophagus with extraluminal air next to the esophagus.

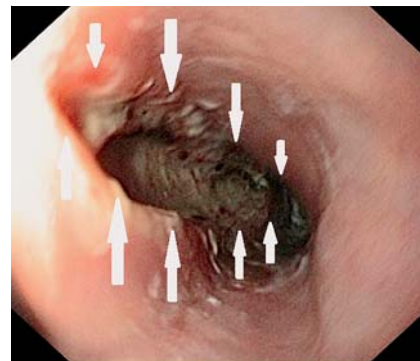


Fig. 2 Endoscopy revealed a long perforation in the esophagus (arrows).

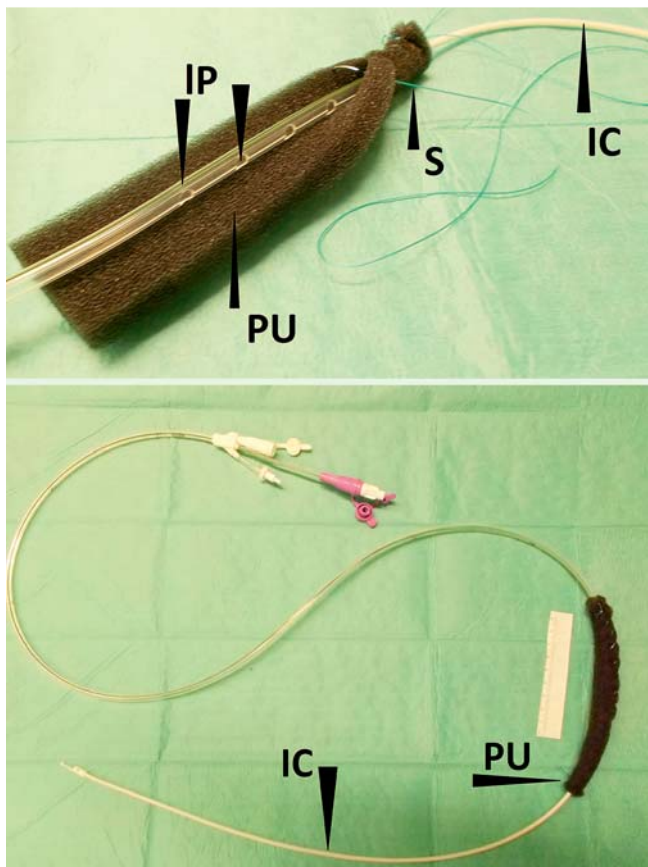


Fig. 3 Construction of the double-lumen vacuum drainage device. PU, polyurethane foam; S, suture; IP, lateral perforations of the gastric channel; IC, intestinal feeding channel of the tube.

An intraluminal variant of endoscopic vacuum therapy (EVT) [1,2] was used in a case of acute spontaneous perforation of the esophagus. To enable simultaneous enteral nutrition, a double-lumen vacuum drainage with intestinal feeding tube was constructed.

A 31-year-old woman with the human immunodeficiency virus presented with thoracic pain and dysphagia after vomiting caused by a bolus of dry fish. Computed tomography revealed a perforation of the thoracic esophagus with discharge of air (Fig. 1). Endoscopy found an

acute transmural perforation from 26 cm to 31 cm (Fig. 2). Intraluminal EVT [1, 2] was started within 24 hours after the perforation event.

A triluminal tube (Freka Trelumina, CH/Fr 16/9, 150 cm; Fresenius Kabi AG, Bad Homburg, Germany) was used to construct a double-lumen vacuum drainage device (Fig. 3). First, the ventilation channel of the tube was blocked with a clamp, as it was not required for the procedure. Then the tube was inserted nasally and guided out orally. All openings of the drainage channel were wrapped in a 15-cm length of open-pore polyurethane foam (Suprasorb CNP; Wundschau, Lohmann & Rauscher GmbH & Co. KG, Neuwied, Germany), and secured with a suture. The double-lumen drainage device was then inserted endoscopically and the intestinal feeding channel was placed in the stomach. The open-pore polyurethane foam section of the tube covered the perforation region completely. After application of negative pressure with an electronic device (KCI V.A.C. Freedom; KCI USA Inc., San Antonio, Texas, USA; setting -125 mmHg, continuous, intensity 10), the esophageal lumen collapsed around the foam.

Placement of the drainage device (and its removal after treatment) was performed using a standard gastroscope and carbon dioxide insufflation with the patient under general anesthesia. The patient was transferred to a normal ward immediately after drainage placement.

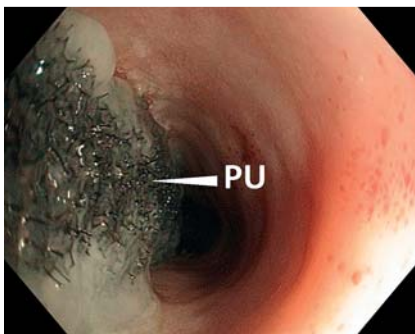


Fig. 4 Day 5 of endoscopic vacuum therapy. The polyurethane foam (PU) had been sucked onto the perforation wound.

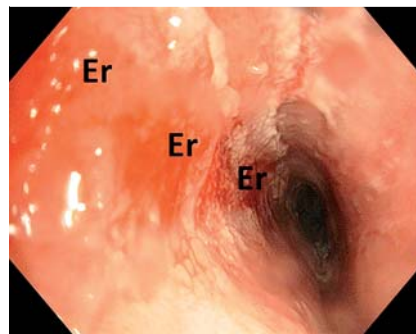
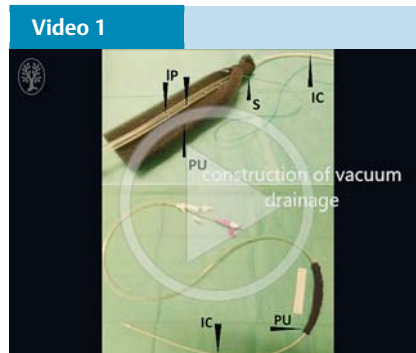


Fig. 5 Day 5 of endoscopic vacuum therapy. Vacuum drainage was removed, revealing the former perforation site, which showed an erosion pattern (Er).



Fig. 6 At follow-up endoscopy 18 days after treatment, complete healing was achieved and an esophageal pseudodiverticulus was found.



Endoscopic vacuum therapy for perforation of esophageal pseudodiverticulus.

After EVT for 5 days, the drainage device was removed by pulling the tube. The foam had been sucked onto the perforation wound (▶ **Fig. 4**), which was closed and covered with an erosive pattern (▶ **Fig. 5**). No fistula could be observed. Three days after the end of therapy, a small ulceration could be seen at the site of the former perforation, and after 18 days, complete healing of the perforation region was achieved. In addition, an intramural esophageal pseudodiverticulus (▶ **Fig. 6**) was detected as a possible explanation for the perforation. Double-lumen vacuum drainage with intestinal feeding tube enabled full enteral nutrition from the beginning of esophageal intraluminal EVT (▶ **Video 1**).

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Competing interests: G. Loske is a consultant for Lohmann & Rauscher GmbH & Co. KG.

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Bibliography

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