Subacute food bolus obstruction secondary to a migrated Overstitch suture from a previous esophageal perforation repair

The Overstitch device has been used for closure of esophageal perforations [1]. A 40-year-old woman with type I achalasia underwent fluoroscopic pneumatic dilation in September 2015. Her mean lower esophageal sphincter (LES) pressure was 40 mmHg. She had 100% esophageal aperistalsis and absence of LES relaxation. Endoscopy showed a tight but traversable esophagogastric junction (EGJ). A 30-mm achalasia balloon was used to perform dilation for 1 minute at 5 PSI followed by 1 minute at 8 PSI.

She became pyrexial on the third day after dilation. Computed tomography (CT) showed a distal esophageal perforation with a small paraesophageal collection and left basal pleural effusion (Fig. 1). Intravenous antibiotics were commenced and ultrasound-guided aspiration of the pleural fluid yielded 8 mL of hemoserous fluid. An endoscopy on day 6 after dilation showed a 5-mm linear laceration above the EGJ (Fig. 2a). It was repaired with two Overstitch polydioxanone (PDS) sutures using an Olympus 2T160 gastroscope (Fig. 2b). Endoscopy and fluoroscopy 6 days after this repair showed that the repair was intact and the patient was discharged 13 days after the initial dilation. Gastroscopy at 4 weeks after repair showed good healing of the laceration with residual sutures at the repair site (Fig. 2c). The patient’s LES pressure was 20.7 mmHg; however, she was asymptomatic.

At follow-up at 5 months, the patient complained of spasmodic epigastric pain without vomiting or dysphagia. A subse-
quent endoscopy showed good healing of
the perforation site (Fig. 2d); however,
a suture with a 3-cm food bolus around
its T tag was lodged at the D2/3 junction
(Fig. 2e). The suture and the food bolus
was completely removed endoscopically
using rat-tooth forceps (Fig. 2f). The pa-
tient’s symptoms resolved after this pro-
cedure.

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Competing interests: None

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