

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

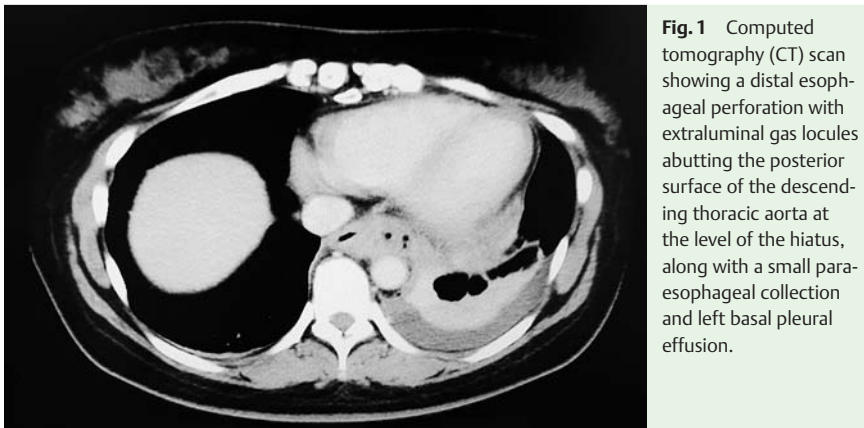
The Overstitch device has been used for closure of esophageal perforations [1]. A 40-year-old woman with type I achalasia underwent fluoroscopic pneumatic dilation in September 2015. Her mean lower

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

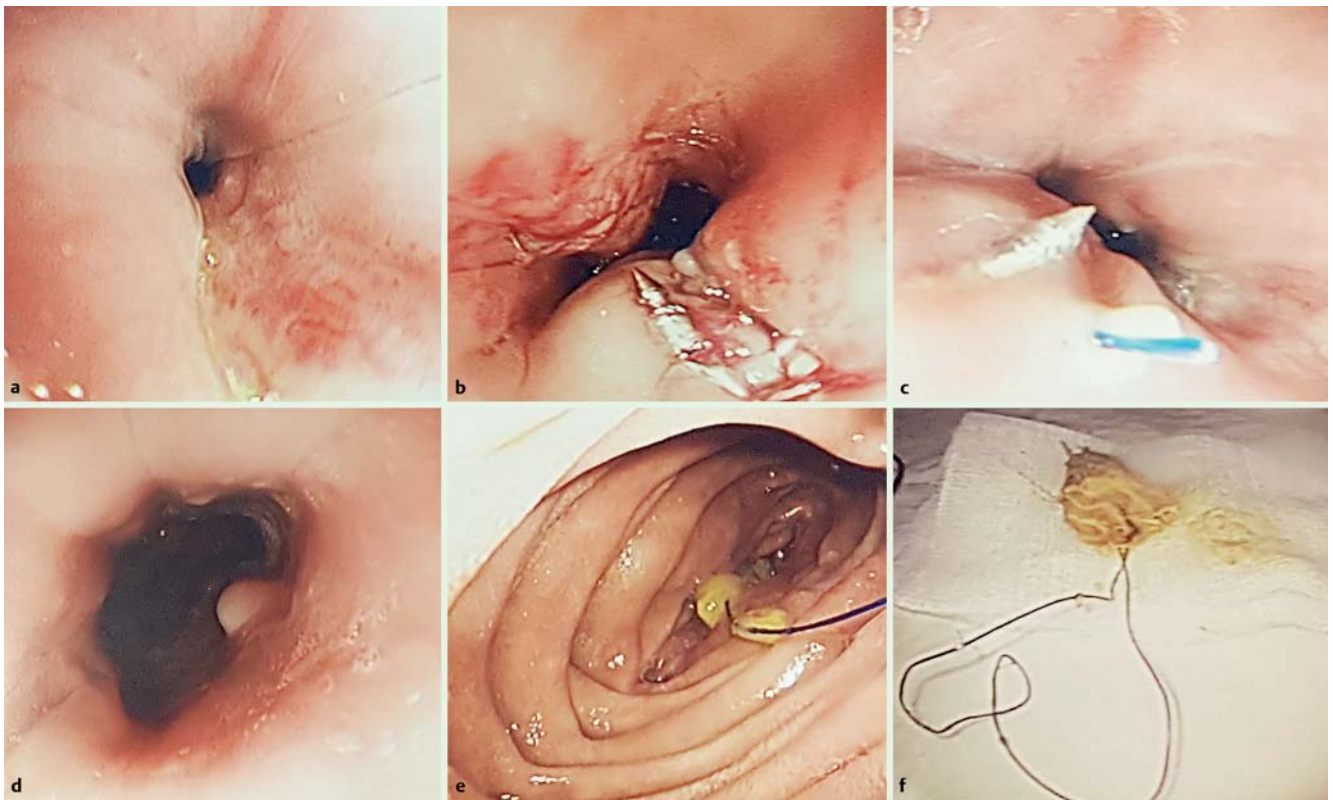
achalasia balloon was used to perform dilation for 1 minute at 5 PSI followed by 1 minute at 8 PSI.

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 hemoerosus 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 gastroscop (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-



**Fig. 1** Computed tomography (CT) scan showing a distal esophageal perforation with extraluminal gas locules abutting the posterior surface of the descending thoracic aorta at the level of the hiatus, along with a small paraesophageal collection and left basal pleural effusion.



**Fig. 2** a–e Endoscopic views showing: a) a 5-mm linear deep laceration just above the esophagogastric junction; b) repair of the laceration with Overstitch polydioxanone (PDS) sutures; c) good healing of the laceration with a residual suture visible at the repair site 4 weeks after the Overstitch repair; d) complete healing of the laceration and no sutures visible at the repair site 6 months after the Overstitch repair; e) the suture that was found lodged at the D2/3 junction during the same endoscopic examination. f) The Overstitch suture along with the food bolus around its T tag after it had been extracted endoscopically.

quent endoscopy showed good healing of the perforation site (● Fig. 2 d); however, a suture with a 3-cm food bolus around its T tag was lodged at the D2/3 junction (● Fig. 2 e). The suture and the food bolus was completely removed endoscopically using rat-tooth forceps (● Fig. 2 f). The patient's symptoms resolved after this procedure.

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**Competing interests:** None

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#### Reference

- 1 Henderson JB, Sorser SA, Atia AN et al. Repair of esophageal perforations using a novel endoscopic suturing system. *Gastrointest Endosc* 2014; 80: 535 – 537

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