Idiopathic Refractory Benign Esophageal Stricture -What Next?

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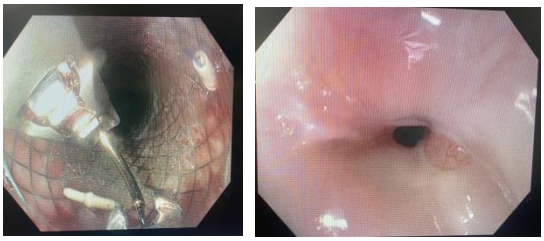
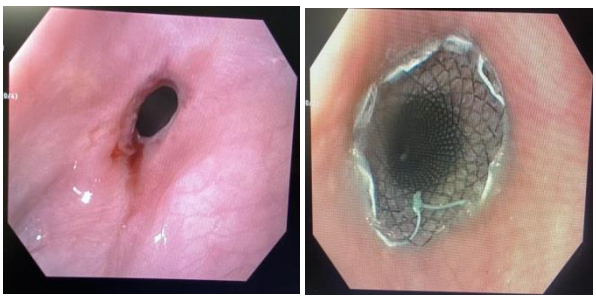
Abstract

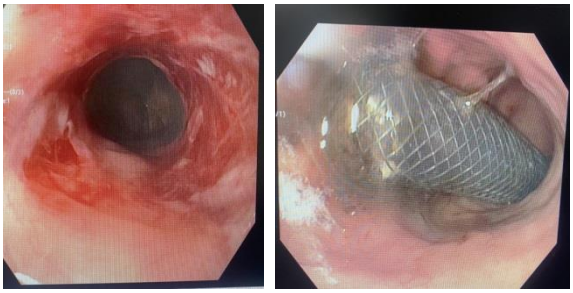
Introduction:
A benign gastroesophageal anastomotic stricture occurs 8 in 100,000. Benign esophageal strictures arise from various etiologies and are frequently encountered. Although endoscopic dilation is still the first-line therapy, recurrent strictures do occur in approximately 10% of the cases and remains a challenge to gastroenterologists. In the era of liberal proton pump inhibitor (PPI) use, benign esophageal strictures remain a significant management problem, with 30-40% of patients experiencing symptomatic recurrence within 1 yr of successful dilation. Here we are presenting a very rare idiopathic benign refractory esophageal stricture.

Case Presentation: A 39 yr old Hispanic female with Past medical history of Helicobacter Pylori Gastritis presented with worsening dysphagia of one month duration. Patient states that she can barely tolerate solid foods and it feels as though they get stuck in her esophagus. She states it feels like a burning pain as well in midsternal area. Patient states she has made adjustments to her diet and takes Proton pump inhibitor daily with no effect. Patient denies any blood in stools or changes in stool habits. Patient denies fevers, arm/jaw pain, nausea, vomiting, diarrhea, constipation, or any other symptoms at this time. Esophagogram showed a focal high-grade stricture of the mid to distal esophagus. Pt had EGD which showed a stricture at the level of 28cms from Incisors and not able to advance the scope, undergone balloon dilatation up to 12mm and was able to advance the scope after dilatation which showed normal esophagus and GE junction underneath the stricture with no signs of acid reflux and was discharged to home on PPI and Sucralfate. Biopsy at the stricture came back as non-specific inflammation. Later patient came back in 10 days with severe dysphagia not able to swallow any liquids or Solids, Emergency EGD performed and again showed the previous stricture with similar degree of narrowing and unable to advance the scope. Pt had undergone balloon dilatation again up to 15 mm and was sent home on previous medication to follow up EGD in 2 weeks. But patient returned hospital in a week time with similar complaints had third time balloon dilatation up to 18mm with due surveillance EGD in 2 weeks but again patient returned back in one week had fourth time balloon dilatation up to 18mm. This time decision was made to place the esophageal stent if symptoms recurred. After 10 days of fourth dilatation patient underwent EGD for 23x105 mm wall flex covered stent esophageal stent placement under Fluoroscopy guidance as symptoms came back but stent is removed in 2 days as patient is unable to tolerate it with severe reflux symptoms. Patient go second time similar stent placement in 2 weeks and stent is supported with endo clips to keep in position. Pt did well for 4 weeks without any symptoms and was started, complaining epigastric pain during 5th week for which she underwent EGD which showed stent migrated to stomach which was removed. Pt is scheduled for one more similar esophageal stent in 10 days along with steroid injection (40mg of Triamcinolone diluted in 10ml saline injected equally in all four quadrants of the stricture) and three endo clips applied to prevent migration. After 3 weeks did one more EGD as patient complaining of severe epigastric pain to remove the stent along with one more time steroid injection. Patient symptoms improved minimally but still have some difficulty in eating solid food. Electively we did place one more similar esophageal stent and this time we used Endo Sutures to keep the stent in place. Unfortunately, patient started complaining the severe epigastric pain within 3 days of stent placement and Chest x-ray showed migration of the stent, which was removed next day by removing the sutures.

Discussion: Management of anastomotic strictures may require extended periods of serial endoscopic dilation, with significant risk, cost, and inconvinence for the patient







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