

Endoscopic ultrasound-guided recanalization of complete pharyngoesophageal stenosis

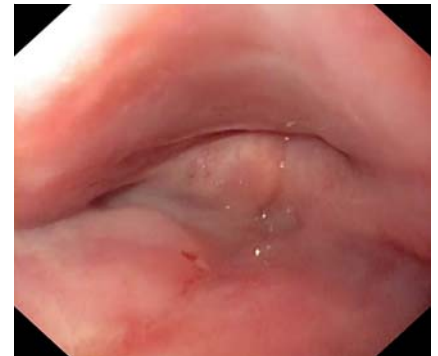


► **Fig. 1** Esophagogram showing complete obstruction of the esophagus and passage of contrast into the airway.

A 74-year-old man was referred because of complete esophageal obstruction. He had a diagnosis of T3N1 hypopharyngeal squamous cell carcinoma and had undergone chemoradiotherapy with a complete response. He had a percutaneous endoscopic gastrostomy (PEG) for nutrition and had had aphagia for 18 months. Assessment of the stricture using contrast swallow demonstrated complete esophageal obstruction (► **Fig. 1**), and combined anterograde (peroral) and retrograde endoscopy (through the feeding gastrostomy tract) revealed complete

esophageal obstruction at the level of the upper esophageal sphincter (► **Fig. 2**, ► **Fig. 3**). An attempt at rendezvous was unsuccessful [1].

We decided to perform the procedure guided by endoscopic ultrasound (EUS) (► **Video 1**). Through the PEG, a guidewire was advanced into the upper esophagus and an endoscopic retrograde cholangiopancreatography (ERCP) extractor balloon inserted over the guidewire. The balloon was filled with contrast to give a visible target on EUS. However, the balloon was not adequately identified with



► **Fig. 2** Peroral endoscopy. Complete obstruction at the upper esophageal sphincter.



► **Fig. 3** Retrograde endoscopy through the feeding gastrostomy tract. Complete obstruction in the upper esophagus.



► **Fig. 4** The guidewire passing into a suitable position in the esophagus.



Video 1 Endoscopic ultrasound-guided recanalization of complete esophageal obstruction.

the echoendoscope positioned in the hypopharynx.

On fluoroscopy, a separation between the balloon and the echoendoscope was observed, by which contrast was introduced through the lumen of the balloon. EUS now showed a good target in the esophageal lumen. With a 19-G needle, the esophageal lumen was punctured and a 0.025-inch Visiglide guidewire advanced. The echoendoscope was removed, and adequate positioning of the guidewire was verified with a gastroscopy (► Fig. 4). A 6-Fr cystotome and a 6-mm dilation balloon were used to create a passage, followed by placement of a 12-Fr jejunal probe to keep the passage patent.

After 7 days, regular dilation sessions were started with Savary bougienage to 16-mm in diameter. In two of the sessions, mitomycin was injected at the level of the stenosis. After 13 dilations, ade-

quate tolerance of a normal diet was achieved and the PEG was withdrawn. At 3 years' follow-up, no recurrence of stenosis was seen.

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Competing interests

Dr. J. R. Aparicio is a consultant for Boston Scientific.

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