A 69-year-old man underwent an upper gastrointestinal endoscopy, which revealed a large submucosal lesion in the distal esophagus with normal overlying mucosa. Endoscopic ultrasound (EUS) showed a hypoechoic lesion measuring $80 \times 40 \times 30$ mm in the submucosa (Fig. 1). A subtotal esophagectomy was performed. Histopathological examination of the resected tissue revealed a duplication cyst.

The patient developed sepsis 3 weeks after surgery. A computed tomography (CT) scan revealed evidence of dehiscence of the esophagogastric anastomosis with a large mediastinal collection (Fig. 2). Upper gastrointestinal endoscopy confirmed the presence of a dehiscence affecting an 8-mm section of the esophagogastric anastomosis (Fig. 3a). Pus was aspirated through the fistula orifice and two double-pigtail plastic stents were placed endoscopically to drain the abscess (Fig. 3b). There was rapid improvement in the patient’s clinical condition. After 1 week, the stents were removed and an over-the-scope clip (OTSC) was applied to close the fistula. Unfortunately, despite this, a Gastrografin swallow revealed persistence of the fistula.

A third upper gastrointestinal endoscopy was performed and after removing the OTSC, we applied argon plasma coagulation (APC) and three through-the-scope clips, which effectively sealed the fistula (Fig. 3c). Resolution of the mediastinal abscess as well as the fistula was confirmed on a further thoracic CT scan and Gastrografin swallow (Fig. 4). This case highlights the potentially useful role of endoscopic drainage and clipping devices in the management of a rare but serious adverse event of esophageal surgery.

### Competing interests: None
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