Endoscopic pyloromyotomy for postesophagectomy gastric outlet obstruction

Postesophagectomy gastric outlet obstruction occurs in 20%-30% of patients who undergo esophagectomy and is associated with significant morbidity and delayed recovery [1]. Recently, endoscopic pyloromyotomy, also called gastric peroral endoscopic myotomy (POEM), has been reported, in pigs and in a patient with refractory diabetic gastroparesis [2,3]. We report a case of postesophagectomy delayed gastric emptying that was successfully treated with endoscopic pyloromyotomy.

A 54-year-old woman was referred to the gastroenterology department because of vomiting 2 weeks after esophagectomy with gastric pull-up for esophageal squamous cell carcinoma. Esophagography revealed marked delay in passage of contrast through the pylorus and the endoscope could not be passed through the pylorus. Endoscopic pyloromyotomy was performed with the patient under conscious sedation. Saline solution mixed with indigo carmine was injected on the greater curvature 5cm proximal to the pylorus. A 1.5-cm mucosal incision was made using a DualKnife (KD-650L; Olympus, Tokyo, Japan). Submucosal tunneling towards the pylorus was done using Endocut I (E2-D2-I3) (VIO 300D; ERBE, Tübingen, Germany) and Swift Coag modes (E4-40W). When the scope reached the pylorus, selective circular and/or oblique myotomy was done. The outer longitudinal muscle was preserved. The mucosal entry was then closed using four endoscopic clips (Video 1).

On the following day, fluoroscopy showed significant improvement in passage of contrast (Fig. 3) and the gastroscope (GIF-H260; Olympus) could pass smoothly through the pylorus. The patient was started on a liquid diet and was discharged the next day. She remains well 10 weeks after the procedure and appropriately tolerates a general diet.

The mucosal entry was then closed using four endoscopic clips (Video 1).

Endoscopic pyloromyotomy was carried out to treat postesophagectomy delayed gastric emptying.

Competing interests: None

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Video 1

Endoscopic pyloromyotomy carried out to treat postesophagectomy delayed gastric emptying.

Fig. 1 A 54-year-old woman presented with vomiting 2 weeks after esophagectomy with gastric pull-up.
a Esophagography revealed marked delay in passage of contrast through the pylorus.
b Fluid retention was noted on esophagogastroduodenoscopy (EGD) and the scope could not be passed through the pylorus.
References

3 Khashab MA, Stein E, Clarke JO et al. Gastric peroral endoscopic myotomy for refractory gastroparesis: first human endoscopic pyloromyotomy (with video). Gastrointest Endosc 2013; 78: 764 – 768

Bibliography

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Fig. 2 Endoscopic pyloromyotomy: a creation of mucosal entry; b submucosal tunneling; c pyloromyotomy; d closure of mucosal entry.

Fig. 3 Fluoroscopy on the day after endoscopic pyloromyotomy showed significant improvement in the passage of contrast.