Over-the-scope clip (OTSC) closure of a gastrobronchial fistula after esophagectomy

A 60-year-old man with Barrett carcinoma underwent thoracoabdominal esophagectomy with reconstruction by gastric pull-up and tubularization of the gastric conduit. The ventral part of the esophagogastroduodenoscopy was covered with the remnant gastric fundus as an anterior hemiplication of the gastric conduit.

One year later, the patient developed a persistent cough, especially in a recumbent position. Assessments by endoscopy (gastroscopy, bronchoscopy) and computed tomography (CT) scan did not reveal any evidence of an intestinobronchial fistula. Finally, the patient was treated for psychogenic coughing.

The procedure was performed under general anesthesia. An 11/6t OTSC (Ovesco Endoscopy, Tübingen, Germany) was chosen. No grasper or anchor could be used owing to the narrow conditions in the small gastric plication. The fistula opening was only aspirated in the OTSC cap (Fig. 2a). Simultaneous bronchoscopy confirmed no narrowing of the bronchial lumen during clip application (Fig. 2b).

After the procedure, the patient reported being symptom free. Endoscopic control 3 weeks later showed the OTSC in the gastric plication surrounded by granulation tissue. On bronchoscopy, the fistula had completely healed. The clip was still in situ 7 months later and the patient free of symptoms (Fig. 3).

To our knowledge, this is the first report of successful gastrobronchial fistula closure with an OTSC. There are only two cases of successful OTSC fistula closures (one esophagobronchial and one esophagotracheal) [1, 2] and one describing a combined approach (OTSC and self-expandable covered metal stent) [3]. In our case, the clip may have grasped not only the thin fistula wall but also well-perfused tissue of the gastric plication. This might have promoted healing of the fistula.

In conclusion, the use of an OTSC is justified when attempting gastrobronchial fistula closure.

Endoscopy_UCTN_Code_TTT_1AO_2AI

Competing interests: None
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DOI http://dx.doi.org/10.1055/s-0034-1390729
Endoscopy 2014; 46: E638–E639
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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