Subacute food bolus obstruction secondary to a migrated Overstitch suture from a previous esophageal perforation repair

The Overstitch device has been used for closure of esophageal perforations [1]. A 40-year-old woman with type I achalasia underwent fluoroscopic pneumatic dilation in September 2015. Her mean lower esophageal sphincter (LES) pressure was 40 mmHg. She had 100% esophageal aperistalsis and absence of LES relaxation. Endoscopy showed a tight but traversable esophagogastric junction (EGJ). A 30-mm achalasia balloon was used to perform dilation for 1 minute at 5 PSI followed by 1 minute at 8 PSI. She became pyrexial on the third day after dilation. Computed tomography (CT) showed a distal esophageal perforation with a small paraesophageal collection and left basal pleural effusion (Fig. 1). Intravenous antibiotics were commenced and ultrasound-guided aspiration of the pleural fluid yielded 8 mL of hemoserous fluid. An endoscopy on day 6 after dilation showed a 5-mm linear laceration above the EGJ (Fig. 2a). It was repaired with two Overstitch polydioxanone (PDS) sutures using an Olympus 2T160 gastroscope (Fig. 2b). Endoscopy and fluoroscopy 6 days after this repair showed that the repair was intact and the patient was discharged 13 days after the initial dilation. Gastroscopy at 4 weeks after repair showed good healing of the laceration with residual sutures at the repair site (Fig. 2c). The patient’s LES pressure was 20.7 mmHg; however, she was asymptomatic.

At follow-up at 5 months, the patient complained of spasmodic epigastric pain without vomiting or dysphagia. A subse-

---

**Fig. 1** Computed tomography (CT) scan showing a distal esophageal perforation with extraluminal gas locules abutting the posterior surface of the descending thoracic aorta at the level of the hiatus, along with a small paraesophageal collection and left basal pleural effusion.

**Fig. 2** a–e Endoscopic views showing: a a 5-mm linear deep laceration just above the esophagogastric junction; b repair of the laceration with Overstitch polydioxanone (PDS) sutures; c good healing of the laceration with a residual suture visible at the repair site 4 weeks after the Overstitch repair; d complete healing of the laceration and no sutures visible at the repair site 6 months after the Overstitch repair; e the suture that was found lodged at the D2/D3 junction during the same endoscopic examination. f The Overstitch suture along with the food bolus around its T tag after it had been extracted endoscopically.
quent endoscopy showed good healing of the perforation site (Fig. 2d); however, a suture with a 3-cm food bolus around its T tag was lodged at the D2/3 junction (Fig. 2e). The suture and the food bolus was completely removed endoscopically using rat-tooth forceps (Fig. 2f). The patient’s symptoms resolved after this procedure.

Endoscopy_UCTN_Code_CPL_1AH_2AJ

Competing interests: None

Baldwin P. M. Yeung, Shannon M. Chan, Philip W. Y. Chiu
Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong, China

Reference

Bibliography
DOI http://dx.doi.org/10.1055/s-0042-106965
Endoscopy 2016; 48: E177–E178
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Baldwin P. M. Yeung, MBChB, PhD
Chinese University of Hong Kong – Surgery
30-32 Ngan Shing Street
Shatin
NT Hong Kong
Hong Kong
China
Fax: +852-26377974
byeung@doctors.net.uk