Endoscopic retrieval followed by compression hemostasis using a Sengstaken–Blakemore tube to manage a foreign body with suspected aortic injury

A 44-year-old woman presented with unremitting chest pain after a fish meal. A fishbone had been stuck in her esophagus overnight. A local endoscopist had tried to remove it but had failed. Contrast-enhanced computed tomography (Fig. 1) confirmed that there was a high density line shadow in the esophagus just below the tracheal bifurcation. The fishbone had pierced the esophageal wall and was close to the descending aorta (arrow).

With written informed consent, an innovative endoscopic strategy involving multidisciplinary cooperation was successfully employed (Video 1). Using endoscopic imaging, the tip of the fishbone could be observed, 28 cm from the incisors (Fig. 2). Grasping forceps were introduced and a 2.2 cm-long fishbone was successfully retrieved (Fig. 3). Then fresh blood immediately spurted out. After flushing with normal saline, a Sengstaken–Blakemore tube (SBT) was immediately inserted. The gastric balloon was placed accurately over the mucosal wound, inflated with 100 mL of gas, and adjusted for local compression...

**Video 1**
Endoscopic retrieval of a fishbone followed by compression hemostasis using a Sengstaken–Blakemore tube. Postoperative care and examinations are also presented.
hemostasis (Fig. 4). The SBT was deflated under endoscopy 20 h postoperatively. Only mild mucosal erosion was observed and there was no active bleeding (Fig. 5). The patient’s postoperative course was uneventful (Fig. 6). Endoscopic management is necessary in only 10%–20% of foreign-body cases, while fewer than 1% require a standard surgical procedure [1]. For patients with suspected injury of the descending aorta or life-threatening esophagus–aorta fistula, surgical management is commonly recommended. In previous reports, an SBT has been used to control the arterial hemorrhage before unavoidable surgery [2,3]. In our patient, the inflating gastric balloon was not used as a preoperative intervention, but was effectively applied for local compression hemostasis immediately after an endoscopic procedure. Tailored adjustment of compression and its duration was important for successful treatment. This combined strategy is minimally invasive, feasible, and safe, and could provide an alternative approach to surgical treatment for patients at high risk. Further research is necessary to weigh the clinical benefits against the potential complications of this strategy.

Competing interests: None

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Acknowledgments

This study was supported by the National Natural Science Foundation of China (81172266&81302107), the Life Health Technology Foundation of Jiangsu province (BL2012031), and the “333 Engineering” Foundation of Jiangsu province (BRA2015472).

References


Bibliography

DOI http://dx.doi.org/10.1055/s-0042-112973
Endoscopy 2016; 48: E281–E282
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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