LETTER TO THE EDITOR

Oesophageal Crohn's disease: A novel approach to managing iatrogenic perforation of an oesophageal Crohn's stricture

Dear Sir,

The prevalence of oesophageal Crohn's disease (CD) is 0.3–2.0%.1 Management is with corticosteroids, 5-aminosalicylic acids, immunomodulators or biologics as for active CD elsewhere plus acid suppression with proton pump inhibitors or H2-receptor antagonists.1 Strictures are additionally treated with repeated dilatations.1 Surgery for strictures is reserved as a final option, because of the associated risk of operative morbidity as well as local recurrence.2 Spontaneous perforation and local fistula formation are reported, typically requiring surgery.

We report a case of perforated oesophageal CD, which we managed with a novel approach. A 40-year-old man with extensive CD presented with dysphagia. He previously had right hemicolectomy and small bowel resection, with resulting strictures requiring dilatation at surgical anastomosis sites. His CD was refractory to medical management, and required autologous stem-cell transplantation previously.

Gastroscopy revealed a 2 cm fibrotic stricture in the mid-oesophagus at 25 cm. Through-the-scope (TTS) balloon dilatation had been performed 3-times previously to this stricture without complication. On this presentation, the stricture was not traversable (Olympus GIF-H260, 10 mm diameter) and TTS balloon dilatation at 12 mm was performed (Boston Scientific CRE-wireguided). On extubation, inflammation and a full thickness mucosal tear were noted. He was transferred to our centre where Gastrografin swallow confirmed perforation (Fig. 1A). He was managed with intravenous co-amoxiclav and total parenteral nutrition. In view of the risk of poor healing, all treatment options were considered including oesophageal resection. A removable covered self-expanding metal stent (Niti-S, 18 mm/80 mm, Pyramed) was deployed with radiological control. He represented 6-weeks later; Gastrografin swallow confirmed distal stent migration, and proximal stricture recurrence but no contrast leak (Fig. 1B). Endoscopic stent removal and stricturotomy using electrocautery via a sphincterotome were completed under anaesthesia without complication.

The aim of the stent was to avoid surgical resection by controlling the perforation, and not to prevent stricture recurrence. In this instance, this would be an unrealistic aim. The approach described above has resulted in a successful long-term outcome, the patient being able to eat normally without evidence of active inflammatory oesophageal disease on lansoprazole, azathioprine and adalimumab, 3-years from his initial presentation. His intermittent dysphagia continues to require cautious repeated dilatation.

To the best of our knowledge, this is the first reported case of perforated oesophageal CD managed successfully with a removable stent. CD strictures complicated by perforation or fistula formation generally require surgical management. Covered self-expanding metal stents avoid the need for surgery following oesophageal perforation in other benign pathology.3,4 Successful outcome for post-iatrogenic perforation in one series was 94%.4 Stenting also allows rapid initiation of oral nutrition.4 Self-expanding plastic stents and biodegradable stents may be superior with fewer complications (primarily early stent failure because of migration), but their use in oesophageal CD is not described. Following stent migration, incisional therapy with electrocautery was used to relieve the dysphagia. This technique is used for managing resistant post-anastomotic strictures and resistant Schatzki rings. It is equivalent to dilatation for the relief of dysphagia, and is generally safe.5

Conflict of interest

PMI is on the Adalimumab board and is a speaker for Abbvie.

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References


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