Case Snippets

Metal endoprosthesis for carcinoma esophagus complicating achalasia cardia

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A self-expanding metallic esophageal prosthesis was placed in a patient with carcinoma esophagus complicating achalasia cardia. Dysphagia was successfully palliated at 9 months follow up. [Indian J Gastroenterol 1998; 17: 150]

Key words: Esophageal cancer

Achalasia cardia is an established risk factor for the development of squamous cell carcinoma. Self-expanding metal endoprostheses provide satisfactory palliation of dysphagia in malignant esophageal strictures and offer several advantages over rigid plastic stents.

We report a patient with carcinoma esophagus complicating long-standing achalasia cardia whose symptoms were successfully palliated by placement of a self-expanding metal stent.

A 50-year-old woman was diagnosed to have achalasia cardia when she presented with episodic dysphagia and barium swallow revealed a smooth narrowing of the lower esophagus with proximal dilatation. Fluoroscopy showed evidence of diminished peristalsis of the esophageal body. Upper gastrointestinal endoscopy had revealed normal esophageal and gastric mucosa. She underwent pneumatic dilatation for achalasia, with substantial improvement in her symptoms. Six years later she started experiencing dysphagia again. Dysphagia was rapidly progressive and she lost 8 Kg body weight over 6 months. Barium swallow now revealed a stricture at the lower end of the esophagus with irregular margins and a filling defect (Fig). At upper gastrointestinal endoscopy there was nodularity of the lower esophageal mucosa starting at 35 cm, with an ulcerated, polypoid mass extending up to the gastroesophageal junction. The endoscope was negotiated across the narrowing only after dilatation. Biopsy from the lesion showed poorly differentiated squamous cell carcinoma. CT scan revealed locally advanced disease with mediastinal lymph nodal enlargement. As this precluded any curative attempt, palliation of dysphagia was planned.

The stricture was dilated up to 12.8 mm by Savary-Gilliard dilators and a self-expanding metal esophageal stent (Ultraflex, Microvasive, Boston Scientific Corporation, USA) was positioned across it. Full expansion of the stent was ensured by inflating a balloon in the prosthesis. The procedure was uncomplicated and the patient was allowed semisolid food the next day.

About a week after the prosthesis placement, she complained of dysphagia immediately after a heavy meal. Repeat endoscopy showed a bolus of rice stuck in the lumen. This was pushed into the stomach using a 'through-the-scope' balloon and cytology brush. The patient was advised to avoid solid meals and to consume small amounts at a time. During a nine-month follow-up, she has been eating without any difficulty and has gained 3 Kg body weight.

Small delivery device and gradual expansion to the maximum diameter over days makes self-expanding metal esophageal endoprosthesis technically more advantageous, less traumatic and better tolerated than conventional rigid plastic stents.

To our knowledge, use of metal stents in carcinoma complicating achalasia cardia has not been reported so far. Our patient had one episode of food bolus impaction in the early post-stent placement period. This complication occurs even in patients without achalasia; however, such impaction might be more likely in patients with carcinoma complicating achalasia cardia.

Despite this fear, we feel that metal endoprostheses can serve as a good palliation for carcinoma complicating achalasia cardia.

References


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Fig: Barium esophagogram showing achalasia cardia (left) and subsequent carcinoma of the esophagus

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