

Transcript Details

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Exploring a New Approach to the Treatment of Esophageal Perforations

Announcer:

You're listening to *Gi Insights* on ReachMD. On this episode, we're joined by Dr. Todd H. Baron, Professor of Medicine and Director of Advanced Therapeutic Endoscopy at the Division of Gastroenterology and Hepatology, University of North Carolina School of Medicine. Dr. Baron is here to share his approach to treatment for patients with esophageal perforations. Let's hear from him now.

Dr. Baron:

So we see esophageal perforations, not only in iatrogenic, which is what we're talking about today, meaning dilation for strictures, but we do see at least at my center, we're seeing patients with spontaneous esophageal perforations, or Boerhaave syndrome. And the approach is somewhat similar, but we'll stick with let's say you had an iatrogenic perforation at the time of treating an esophageal stricture. So, the biggest thing, of course, is to recognize that you have a perforation. And usually it's fairly obvious that you have a through and through tear. And you're obviously already in there with the endoscope, and so I pass a rigid guidewire. Most of the stents, although not all, are non-through-the-scope stents, although more and more we have through-the-scope placement of esophageal stents, understanding that if you do want to use the through-the-scope stent, you generally have to have a therapeutic channel upper endoscope. So, you may not have use that for your dilation. And it's not, I think, a big deal to do a non-through-the-scope stent placement. So, I will place a rigid guidewire because I may or may not have fluoroscopy. And when you have a rigid guidewire, you don't get the looping in the esophagus; you get a one-to-one transmission of passing the stent. And then I will pass the endoscope alongside the stent in these cases and deploy it under direct endoscopic visualization without the need for performing fluoroscopy in these patients. Although again, if you have it, that's fine, too.

In terms of the type of stent, generally we're going to be placing covered stents. The question is then, do you place a partially covered stent or do you place a fully covered stent? Those are somewhat individualized decisions. Obviously, if you place a fully covered metal stent, the risk of migration is relatively high. In most of these, it's going to be short-term, but you'd be surprised that even some of these stents migrate relatively quickly, and then you lose the effectiveness. If you use a partially covered stent, meaning that the ends of the stents are uncovered the uncovered ends will embed in the tissue and make the risk of migration much, much less. But if they're left in longer meaning more than a couple of weeks, and you're going to get embedding of the tissue with the uncovered metal stent, and can make removal a little more complicated, if you will.

If you are inclined to put a fully covered stent in, there are those that suture stents in place who have suture capabilities, I, despite all the advanced endoscopy I do, I don't do suturing. So, your other option in that case would be to place some sort of clip device and not through the scope clips, because those are too flimsy, they're not robust enough to hold the stent in place. So, we're talking about what's called over-the-scope clips. And there are data to support that will reduce the risk of migration and they're relatively easy to remove later.

So, let's say that you have a patient with a Boerhaave syndrome, who came in fairly ill, they had leakage of fluid by the time they got in, they had drains placed. You don't want to risk, in that patient, a stent migration. And often the Boerhaave syndromes cases often don't have an underlying stricture to actually hold the stent in place. And so, in those cases - and it may be a longer-term situation for those to close. So, in those situations, I often prefer placing a very large diameter, partially covered stent. When I say large diameter, of course, in general in the esophageal stent world, you have diameters anywhere from 16 to 23 at the midbody of the stent, the flanges obviously tend to be 3 to 5 millimeters larger. The GE junction tumors, where you tend to have a higher risk of migration, I'll use the 18-millimeter midbody that generally have a flange of 23 millimeters on each side.

Because you also have to remember - if the distal end is in the stomach, which often it is, of course, in a GE junction perforation, that

distal end doesn't contribute a lot to anchoring because it's free within the stomach. And so, you're really talking about hoping that you have anchoring from the proximal flange by itself because the distal flange is not in the esophagus anymore. So again, I will often use a partially covered stent and then a large diameter.

Now you might say, well, how and when do I remove those? So, let's talk about again, the Boerhaave's case where I've seen those take a longer time to heal. Very, very deep, large tears. I would probably even wait 4 to 6 weeks. So, let's say you go back and you do the endoscopy, and the proximal end is deeply embedded and you're worried about what's going to be the case of removal. There's something called the stent-in-stent removal technique, whereby you place a fully covered esophageal stent through the partially covered stent, and you wait approximately 2 weeks and remove both of them. And what that does, is that the buried wires of the uncovered stent that you may not be able to get to the surface, the fully covered stent causes pressure necrosis with the tissue between the uncovered part and the newly covered part. So, you get this tissue necrosis, which basically brings the wires back to the surface. And then when you go to remove them, you can remove both of them very easily. And I've done that many times and not had that fail.

Otherwise, again, if it's across in the stomach in the distal end, is free floating, as I mentioned you can grab the distal end and invert the stent itself. So, you're basically just inverting it right back onto itself. And often that just peels away the partially covered part of the proximal ends.

And also keep in mind that we're talking about using these for indications that aren't there. Right? So, that's an off-label indication. In fact, use of esophageal stents at the current time, are really for malignant disease, understanding that many of us place them for benign indications. But I just want to preface that that's an off-label use of that device.

Now, let's say you have a post dilation perforation. Generally, those do close fairly quickly. I think you can go back and remove those stents within a couple weeks. I probably wouldn't go back earlier than 1 week. But probably certainly by 2 weeks that should be well closed, and then easy to remove.

Announcer:

That was Dr. Todd H. Baron discussing his approach to esophageal perforations. To access other episodes in this series, visit ReachMD.com/giinsights, where you can Be Part of the Knowledge. Thanks for listening!