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Investigating Esophageal Strictures

Dr. Buch:
The successful treatment of benign esophageal strictures requires both skill and patience. How can we improve the treatment of the strictures? Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. Joining us today is 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 also the author of *Top Tips for Dilation of Benign Esophageal Strictures* published in *Gastrointestinal Endoscopy* March 2022. Welcome to the program, Dr Baron.

Dr. Baron:
Thanks for having me.

Dr. Buch:
Let's dive right in, Dr. Baron. What are the top mistakes made by gastroenterologists when dilating esophageal strictures?

Dr. Baron:
Well, I think the probably the biggest mistake is poor estimation of stricture diameter. And honestly, we're probably not the greatest in terms of visually providing measurements. But I think the diameter of the stricture that you're aiming to dilate is obviously very important, because then you're going to choose your dilation tools and diameters more importantly for the diameter of the stricture.

Dr. Buch:
Thank you. So now, in your article you recommended the endoscopist to consider eosinophilic esophagitis when evaluating patients with suspected benign strictures. Can you please elaborate on this recommendation?

Dr. Baron:
Yes. Well, the main reason to suspect it is that, in general, you're going to have to be a little more gentle in your dilation. But also, it's a disease process that needs medical therapy, not just endoscopic therapy. So, the recognition is very important, because you need to identify it so that you can correctly treat it with what now is topical corticosteroids or elimination diets and things like that.

Dilation does play a role in patients with eosinophilic esophagitis and dysphasia. But generally, not the standalone. So, it needs to be recognized by the endoscopic findings appropriate biopsies taken to establish the diagnosis. And then again, these patients - the main concern with dilation is they often have narrowed esophagi from top to bottom. So again, while you may not perceive that the esophagus is that narrow, if you choose a fairly larger diameter dilator for those patients who have generally small esophagus, then there's a potentially high risk of perforation.

The other is that you tend to have more of a diffuse dilation, meaning you're going to try to dilate the entire esophagus most of the time in those patients if that's your approach rather than just one area, although they can also have focal strictures.

Dr. Buch:
Thank you. How do you decide whether to use a balloon or a wire-guided bougie?

Dr. Baron:
Right, excellent question. So, we don't have randomized trials to guide us as to one or the other. A lot of it is, I think, personal preference. Prior training, who taught you has a great deal to do with it. Personally, I

prefer the rigid dilators in patients with more refractory strictures. And the reason for that is that the bougie, or rigid dilators, provide not only a shearing force, but a radial force. So, there's two mechanisms of action for dilation as opposed to balloon dilation, which is radial

force alone.

The other is that if patients have very, very fibrotic strictures, and you dilate to a balloon, you're assuming that when you go to the PSI, that's called for by the manufacturer, that it actually reaches that diameter. And it may or may not, depending on how fibrotic the stricture is, and you wouldn't know that unless you have dilated under fluoroscopy and you looked for a waist in a balloon. And most people just don't always use fluoroscopies.

Dr. Buch:
Very useful information. Thank you. Dr. Baron, would you perform an esophageal dilation in the same session as removing a significant food bolus?

Dr. Baron:
Also, a great question. You don't want the patient to leave, necessarily with a severe stricture. So if let's say you're able to carefully remove it, you don't see any major trauma related in the endoscopy, the patient has tolerated the procedure well, I think it's reasonable and they're left with, again, this is not just EOE, because EOE, when you clear it, you probably don't have a significant stricture. But if you're done and there's still a significant stricture, I think it's reasonable to do at least a mild dilation to kind of get the patient going get them better quicker, rather than have to bring them back and save them sort of another trip for a dilation.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Todd Baron about benign esophageal strictures.

Dr. Baron, let's turn our attention to refractory strictures. How does your approach to treating these differ from typical esophageal strictures?

Dr. Baron:
So, in patients with refractory strictures, the main thing is I think you have to be more aggressive with the dilation. And not necessarily - I mean, the diameter chosen on a given time, but more bringing the patient back earlier for re-dilation. And so, typically, the patients referred to me have been dilated numerous times, and they haven't made significant progress. And it may be that if they were getting dilated once a month, once every six weeks in which case I will dilate them appropriately, and bring them back early, sometimes as early as a week later, or two weeks later, to try to see if more aggressive, more frequent dilation can make an impact. Again, the patients that you tend to be woefully disappointed with in that regard the head and neck really bad radiation-induced strictures. But I think it's still worth trying to be aggressive and dilate those patients.

The other thing is, I might try something that the other physician or somebody hasn't tried or even myself. So, if I had done balloon dilation and it's not making progress, I might then go to rigid dilators in those cases. And then of course, there are things that we do such as electro-incision for refractory strictures, and electro-incision is the use of electrocautery typically with what's called a needle knife, which is used for ERCP. That tends to be best suited for patients with anastomotic strictures. So, the typical patient there will be somebody who's had what's called an Ivor Lewis operation or, commonly, a distal esophagectomy with an esophageal gastric anastomosis. And those strictures tend to be short. They may look to be readily dilutable, and I still would do that as the first approach. But then surprisingly, sometimes they come back and they've not really responded or they've recurred relatively quickly, or again, after numerous dilations. Those tend to respond very, very well to electro-incision.

The other of course, is use of injectable corticosteroids such as triamcinolone, which we all do for recurrent or refractory strictures. Although the best data to support the use of corticosteroids are derived from the peptic strictures which are less common and less the presenting of refractory strictures. You have to remember, it may or may not be helping. It may be helping the doctor more than the patient, but it's certainly something to try as well in concomitant with dilation.

Dr. Buch:
Great. With those interesting thoughts in mind, I want to thank my guest, Dr. Todd H. Baron, for sharing his insights on treating esophageal strictures. Dr. Baron, it was a pleasure having you on the program.

Dr. Baron:
Thank you for having me. I appreciate it.

Dr. Buch:
This was great. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit reachmd.com/giinsights, where you can be part of the knowledge. Thanks for listening and see you next time.