Endoscopic intervention as a decisive tool in the prognosis of cancer patients

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Dear editor:

We have read with interest the article by Zhang et al (1), regarding the use of cyanacrylate in respiratory fistula. In some patients with malignant esophagorespiratory fistulas, a tracheal prosthesis must also be considered simultaneously with endoscopic treatment in the esophagus. On the other hand, the role of esophageal prostheses is already widely known (2), their main drawback being migration, especially if there is no stenosis. In order to prevent it, fixation devices can be used. This last aspect is especially important in cancer patients receiving antineoplastic treatment because the reduction in tumor size can increase the risk of migration. We think that a good alternative to cyanacrylate, especially in cases of orifices or large tracts in which complications may appear, are the prostheses, which
are also easier to handle in clinical practice.

A 78-year-old male with stage IV squamous cell carcinoma of the esophagus (lymph node metastasis) had an esophageal-pulmonary fistula of neoplastic origin. As a result of this injury, the patient developed pneumonia that required broad-spectrum antibiotic therapy.

The patient was evaluated in a Multidisciplinary Clinical Session. The start of chemotherapy was conditioned by the tumor fistula. The patient was not a candidate for surgical treatment. An upper endoscopy, showed a long, tortuous neoplastic stenosis, with bubble emission through the wall, highly suggestive of the mentioned esophago-respiratory fistula. It was not considered necessary to use contrast for demonstration, to avoid additional complications, into account CT findings (Fig 1-A).

A covered stent was placed (120 x 20mm) with endoscopic and fluoroscopic control, with the distal end through the cardia, the permeability to gastric cavity was demonstrated with contrast and a stentfix (R) dispositive was placed in the proximal cup with a therapeutic gastroscope to avoid migration of the stent (Fig 1-B). Once the fistula was closed, and after completing the antibiotic therapy, the patient was able to start chemotherapy according to the FOLFOX regimen (5-Fluoracil, leucovorin and oxaliplatin).

An endoscopic intervention often is useful for the palliative treatment of cancer patients (3, 4), constituting a valid alternative to surgery (5). However, this case goes further as it constitutes an example of a positive impact on the prognosis of cancer.
If it had not been carried out, the patient would have been exclusively a candidate for symptomatic treatment with a short life expectancy. The multidisciplinary approach to these patients is once again positioned as a key tool.

Bibliography:


Figure 1— A: PET-CT with 18F-FDG. Distal esophageal neoplasia (red arrow), hypermetabolic (SUVmax of 9.4), with air-fluid levels inside, followed by a small amount of right pleural effusion and with a paramediastinal consolidation (yellow arrow) that is also hypermetabolic (SUVmax of 4), compatible with esophageal-pulmonary fistula; B: Covered stent placed through the cardia. Fixation with Stentfix in the proximal cup of the prosthesis (red arrow).