

**Title:**

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DOI: 10.17235/reed.2024.10412/2024

Link: [PubMed \(Epub ahead of print\)](#)

**Please cite this article as:**

López Moreno María Belén, Jiménez Beltrán Víctor, Godoy López María Antonia, García-Cano Jesús. Endoscopic treatment of an esophageal perforation in eosinophilic esophagitis by insertion of a self-expanding metal stent . Rev Esp Enferm Dig 2024. doi: 10.17235/reed.2024.10412/2024.

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## Endoscopic treatment of an esophageal perforation in eosinophilic esophagitis by insertion of a self-expanding metal stent

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Author contributions: Writing – review & editing: M.B.L.M., V.J.B., M.A.G.L., J.G.

Keywords: Esophageal perforation. Self-expanding metal stent. Eosinophilic esophagitis.

Dear Editor:

We present the case of a 29-year-old patient with multiple allergies, mild asthma and rhinoconjunctivitis who reported a history of esophageal impactions after ingestion of solid foods. These episodes resolved spontaneously at home and by self-induced vomiting and never required endoscopic removal.

The patient presented to the emergency department due to a sensation of food impaction lasting more than 12 hours after eating meat the night before, which did not subside with the intake of liquids or self-induced vomiting. Endoscopic evaluation was requested for foreign body extraction.

A meat bolus impacted in the distal esophagus was easily removed using a Roth basket, revealing a severe esophageal stricture that prevented passage of the endoscope into the gastric cavity.

Furthermore, in the same area where the foreign body was previously located, a deep esophageal tear was seen. Given the high suspicion of perforation, the patient was examined, and thoracic and cervical crepitation was observed. It was decided to immediately insert, with only endoscopic control, a partially covered Ultraflex® esophageal stent measuring 18 mm in diameter and 15 cm in length. After insertion, clinical improvement and cessation of crepitation were observed. Broad-spectrum antibiotics were administered, and the patient remained hemodynamically stable throughout. Correct placement of the stent was confirmed by thoracoabdominal CT, with no contrast leakage into the mediastinum. The patient was admitted to the ICU and remained under close monitoring for 48 hours. No signs of mediastinitis or other associated complications appeared. He was transferred to the ward and discharged in the following days with adequate oral tolerance and clinical and analytical stability. The stent was removed by gastroscopy after 15 days and the integrity of the esophagus was verified (figure 1).

## Discussion

First, we must highlight the importance of a thorough esophageal examination in patients who come to the emergency department with food bolus impaction, especially when there is a high suspicion of eosinophilic esophagitis, as is our case. This entity presents with chronic inflammation of the esophageal mucosa that leads to fibrosis and fragility; if untreated, serious complications such as perforation may appear.

Removable esophageal stents are useful for healing perforations and fistulas (1, 2, 3, 4) and have emerged as a safe, effective, and less invasive alternative for the treatment of various esophageal conditions. We think that whenever endoscopic therapy is performed in the esophagus it is convenient to have these stents on hand to immediately resolve a perforation.

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Accepted Article

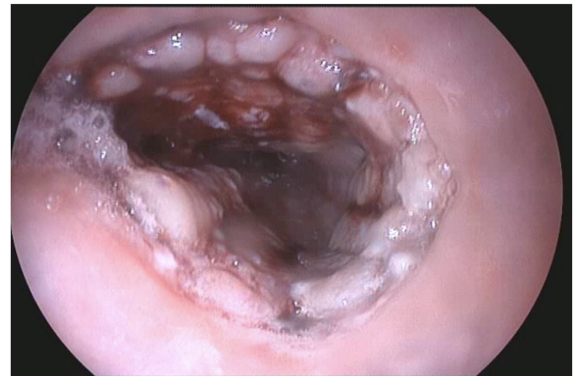
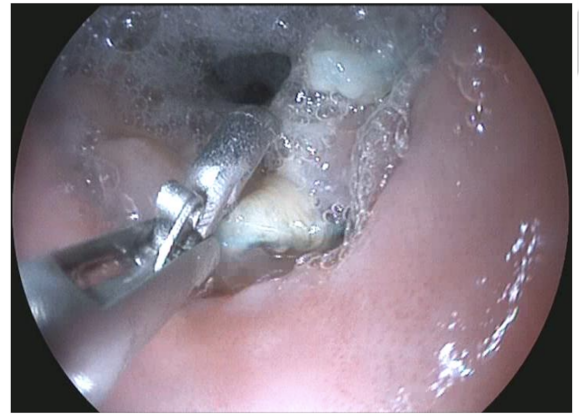
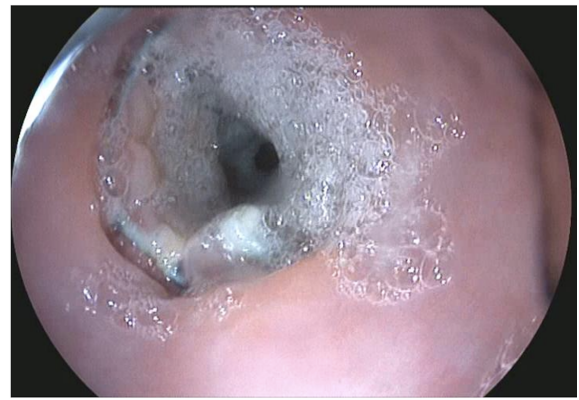


Figure 1. The image on the left corresponds to a CT scan performed immediately after placement of the partially covered Ultraflex esophageal stent. Water-soluble contrast that do not extravasate outside the stent can be observed. The arrow indicates the location of the esophageal stricture. Pneumomediastinum can also be seen. In the right column, from top to bottom: upper end of the stent after 15 days of being in place. The stent could be easily removed by pulling the string with foreign body forceps. After its removal mucosal hyperplasia induced by the uncovered part of the stent is observed. This hyperplasia prevented stent migration.