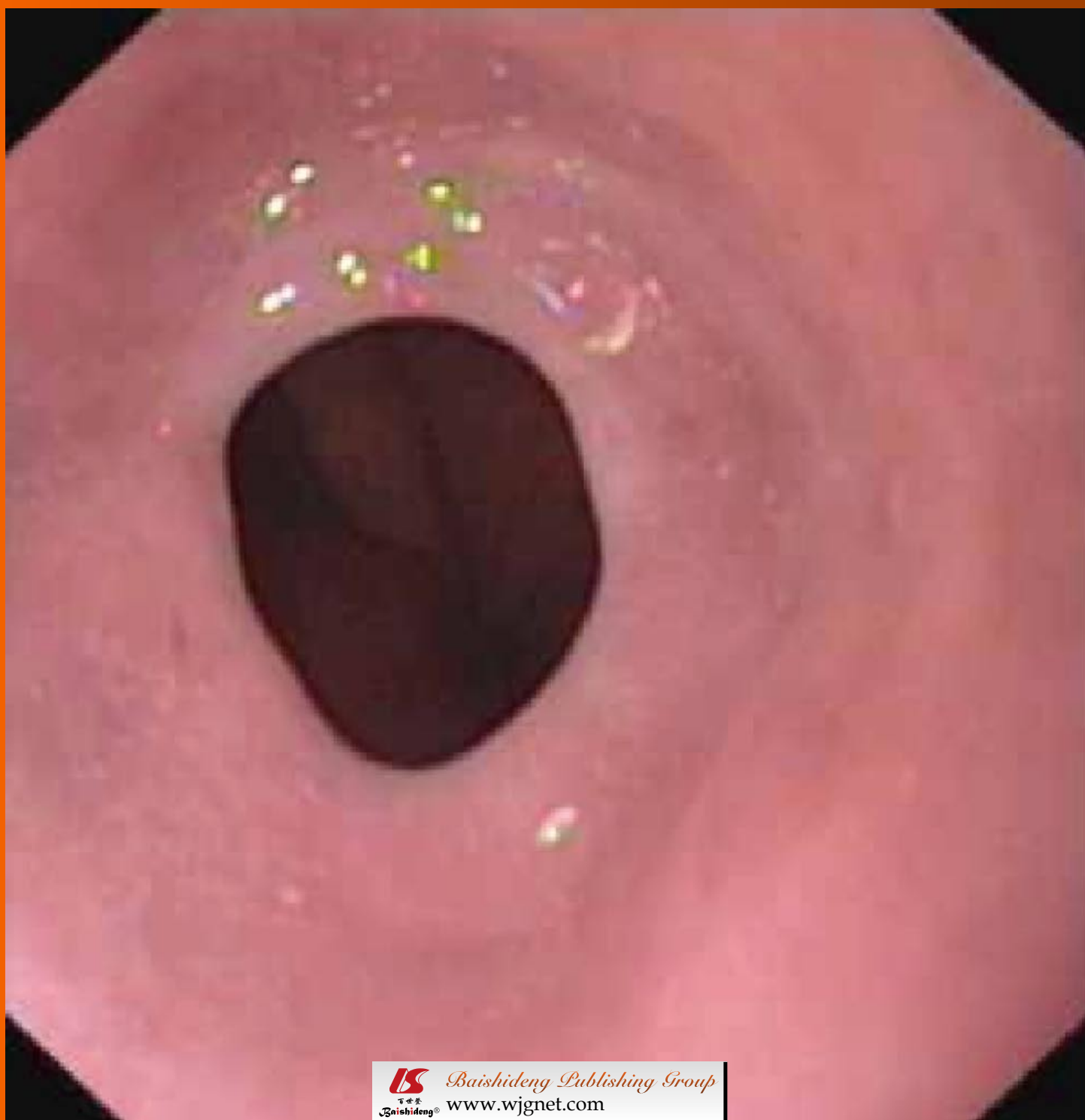


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Safety and outcome using endoscopic dilatation for benign esophageal stricture without fluoroscopy

Nawal Kabbaj, Mouna Salihoun, Zakia Chaoui, Mohamed Acharki, Naïma Amrani

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Author contributions: Kabbaj N, Salihoun M, Chaoui Z and Acharki M performed the technique; Amrani N is the head of the unit; Kabbaj N designed the study and wrote the manuscript.

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Abstract

AIM: To investigate the use of Savary-Gilliard marked dilators in tight esophageal strictures without fluoroscopy.

METHODS: Seventy-two patients with significant dysphagia from benign strictures due to a variety of causes were dilated endoscopically. Patients with achalasia, malignant lesions or external compression were excluded. The procedure consisted of two parts. First, a guide wire was placed through video endoscopy and then dilatation was performed without fluoroscopy. In general, "the rule of three" was followed. Effective treatment was defined as the ability of patients, with or without repeated dilatations, to maintain a solid or semisolid diet for more than 12 mo.

RESULTS: Six hundred and sixty two dilatations in a total of 72 patients were carried out. The success rate for placement of a guide wire was 100% and for dilatation 97%, without use of fluoroscopy, after 6 mo to 4 years of follow-up. The number of sessions per patient was between 1 and 7, with an average of 2 sessions. The ability of patients, after 1 or more sessions of dilatation, to maintain a solid or semisolid diet for more than 12

mo was obtained in 70 patients (95.8%). For very tight esophageal strictures, all patients improved clinically without complications after the endoscopic procedure without fluoroscopy, but we noted 3 failures.

CONCLUSION: Dilatation using Savary-Gilliard dilators without fluoroscopy is safe and effective in the treatment of very tight esophageal strictures if performed with care.

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Key words: Esophageal benign strictures; Dilatation; Savary-Gilliard dilators; Results; Outcome

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INTRODUCTION

Esophageal strictures are a problem frequently encountered by gastroenterologists and can be subdivided into malignant and benign origin. Malignant esophageal strictures are mainly caused by primary esophageal cancer but can also be caused by extra esophageal malignancies that compress the esophagus^[1].

The most common causes of benign esophageal strictures include peptic injury, Schatzki's ring, esophageal web, radiation injury, caustic injury and anastomotic strictures.

Upper endoscopy is the diagnostic procedure of choice

for the detection of an esophageal stricture and its underlying cause. Nevertheless, it is mandatory that biopsy samples are taken to confirm whether the stricture is benign or malignant in nature^[1].

Dilatation of esophageal strictures is a commonly performed procedure used to relieve dysphagia due to esophageal strictures. In clinical practice, fluoroscopy is recommended for monitoring the position of a guide wire and dilator^[2-5]. Some authors, however, believe that fluoroscopy is not necessary for dilatation. The aim of this study is to describe our experience using a guide wire and marked Savary-Gilliard dilators (Figure 1) without the use of fluoroscopy.

MATERIALS AND METHODS

Patients

Between January 2005 and January 2011, 72 consecutive patients (45 females, 27 males, aged 18 to 75 years old, mean age 42 years) with benign esophageal strictures were referred to our unit for dilatation because of persistent or recurrent dysphagia. Benign stricture was ascertained using endoscopy and biopsy. There were 72 benign lesions. The diagnoses are summarized in Table 1. Patients with achalasia, malignant lesions and external compression were excluded. All our patients had various degrees of dysphagia. A total of 662 dilations were performed for 72 patients who had various degrees of dysphagia prior to each session. X-ray studies of the geography of the strictures were performed for each case before treatment.

Instruments

Examinations were performed with Olympus GIF-XP or Pentax EPK-700. Dilatation was performed with marked Savary-Gilliard dilators.

Technique

If the stricture could be passed with a paediatric endoscope, the guide wire was placed through endoscopic guidance. Thereafter, dilatation was performed without fluoroscopy. For very tight esophageal strictures, we inserted the guide wire through the tight stricture into the esophageal lumen and Savary-Gilliard dilatation was also used without fluoroscopy. In general, "the rule of three-dilator size increased step by step" was carried out. If dysphagia and esophageal strictures recurred during the clinical follow-up after completion of a series of dilations, additional dilatation was carried out until symptomatic relief was achieved. All procedures were performed with intravenous sedation (propofol).

Effective treatment was defined as the ability of patients with or without repeated dilations to maintain a solid or semisolid diet for more than 12 mo.

RESULTS

Peptic injury (Figure 2A) was the most frequent cause of

esophageal benign stricture in our series in 41.6% of patients, followed by Plummer Vinson web (Figure 2B) in 27.7% of cases (Table 1).

A total of 662 dilations in 72 patients in 141 sessions were performed. The success rate for the placement of a guide wire was 100% and for dilatation was 97%, without use of fluoroscopy, after 6 mo to 4 years of follow-up. We performed an endoscopy immediately for post procedure bleeding or mucosal tearing. After dilatation, our patients are hospitalized and observed for 6 h. They are clinically examined and in a case of pain, chest X-ray is carried out to check for perforation. Twenty four hours after dilatation, we phone patients to ask if there is any fever or bacteraemia. In our series, there were no adverse events or complications.

The number of sessions per patient was between 1 and 7, with an average of 2 sessions.

The ability of patients after 1 or more sessions of dilatation to maintain a solid or semisolid diet for more than 12 mo was obtained in 70 patients (95.8%).

For very tight esophageal strictures, we replaced the guide wire through the tight stricture into the lumen initially dilated without complications. All patients with very tight strictures had clinical improvement but we noted 3 endoscopic dilatation failures: 2 patients with anastomotic stricture because of tumoral recurrence and 1 patient with radic stenosis; these patients underwent surgery.

DISCUSSION

Benign esophageal strictures are secondary to different causes. In our series, peptic injury was the most frequent lesions, as found in the literature^[6-9].

The mainstay of treatment for benign esophageal strictures is dilatation. Although dilatation usually results in symptomatic relief, recurrent strictures do occur. In order to predict which types of strictures are most likely to recur, it is important to differentiate between esophageal strictures that are simple and those that are more complex^[1,10]. Simple esophageal strictures are defined as focal and straight^[1,10]. Common etiologies include peptic injury (60%-70% of cases) and a Schatzki's ring or web^[10,11]. In most patients with simple esophageal strictures, 1-3 dilations are required to relieve symptoms, with an additional 25%-35% of patients requiring repeat dilations^[11]. In our series, 76% of patients had simple esophageal strictures and needed from 1 to 3 sessions of dilations.

Strictures that are long (> 2 cm), tortuous or associated with a diameter that precludes passage of a normal diameter endoscope are defined as complex esophageal strictures^[10]. The most common causes include caustic ingestion^[12], radiation injury, anastomotic stricture^[13], photodynamic therapy-related stricture and severe peptic injury. Complex esophageal strictures are more difficult to treat than simple esophageal strictures, require at least three dilatation sessions to relieve symptoms and are associated with high recurrence rates. If complex strictures cannot



Figure 1 Savary-Gilliard dilators.

Table 1 Etiologies of esophageal benign strictures

Benign strictures	n (%)
Peptic injury	30 (41.6)
Plummer Vinson web	20 (27.7)
Radic stricture	9 (12.5)
Caustic stricture	6 (8.3)
Anastomotic stricture	6 (8.3)
Post infectious stricture	1 (1.3)

be dilated to an adequate diameter that allows passage of solid food, recur within a time interval of 2-4 wk or require ongoing (more than 7-10 sessions) dilatations, they are considered to be refractory^[10]. Novel treatment modalities for refractory stricture include temporary stent placement and incisional therapy^[1]. In our series, 24% were complex esophageal strictures, caused by radiation injury, caustic ingestion, anastomotic stricture and post-mycosis stricture.

Successful esophageal dilatation involves both successful placement of the guide wire and dilation. This study demonstrates that Savary-Gilliard dilation can be successful without fluoroscopic control. There were no procedure-induced complications. All 72 unselected consecutive patients had significant dysphagia due to different types of esophageal benign pathology. Symptom relief was achieved in 69 patients. The results are similar to that reported by 3 authors^[2,14,15]. However, in two studies, the endoscope was impassable in 5% and 29.4%. For these cases, fluoroscopy was required. During the insertion of the wire, if there is resistance or if the patient starts coughing (which indicates that the wire is inserted into trachea through the fistula), the wire should be withdrawn and reinserted. In order to prevent complications, the “rule of three” was popularized by Boyce^[16]. Dilatation should be terminated when resistance is encountered during these consecutive dilations.

The main complications associated with esophageal dilatation include perforation (can occur in 0.5% to 1.2%)^[6,17], hemorrhage and bacteremia. The reported rate of perforation and massive bleeding is 0.3%; this risk is higher when complex strictures^[18] and caustic strictures^[12] are dilated. It is generally believed that the risk of perforation is minimal if the “rule of three” is applied, meaning that dilation diameters should not increase by more than 3 mm per session^[10]. Pre-dilation diameter and stricture length are established factors that influence the number of dilations required for symptom relief and the

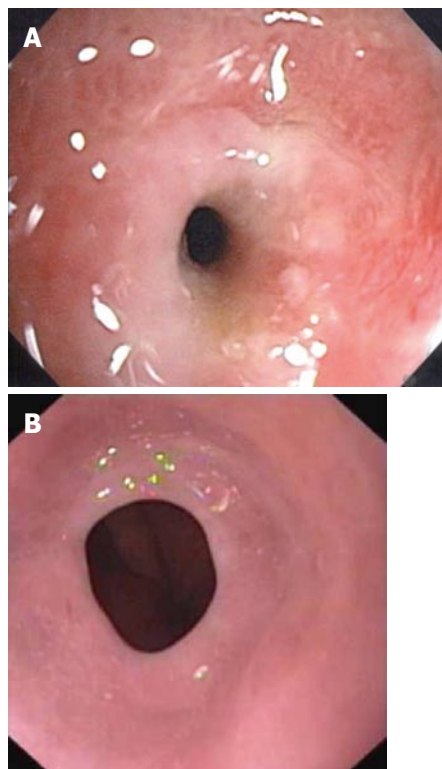


Figure 2 Peptic injury stricture (A) and Plummer-Vinson web (B).

need for additional dilations^[19].

In conclusion, Adequate placement of a guide wire prior to dilation is crucial to achieve successful dilation. With the technique of TTS (through the scope) guide wire insertion, endoscopic dilatation without fluoroscopy is a safe and efficacious way to relieve dysphagia, especially in benign simple strictures. Repeated sessions are necessary to avoid recurrence.

COMMENTS

Background

Esophageal strictures are a problem frequently encountered by gastroenterologists. Upper endoscopy is the diagnostic procedure of choice for the detection of an esophageal stricture and its underlying cause. Dilatation of benign esophageal strictures is a commonly performed procedure to relieve dysphagia. In clinical practice, fluoroscopy is recommended for monitoring the position of a guide wire and dilator. However, some authors believe that fluoroscopy is not necessary for dilatation.

Research frontiers

In the area of treatment of benign esophageal strictures with Savary-Gilliard dilators, the research hotspot is to describe their experience using a guide wire and marked Savary-Gilliard dilators without the use of fluoroscopy and to assess its effectiveness and safety.

Innovations and breakthroughs

In the present study, the authors performed 662 dilatations in 72 patients in 141 sessions. The success rate for placement of a guide wire was 100% and for dilatation was 97%, without use of fluoroscopy, after 6 mo to 4 years of follow-up. The authors performed an endoscopy immediately for post procedure bleeding or mucosal tearing. After dilatation, the patients of this study are hospitalized and observed for 6 h. They are clinically examined and in a case of pain, chest X-ray is carried out to check for perforation. Twenty four hours after dilatation, the authors phone patients to ask if there is any fever or bacteraemia. In their series, there were no adverse events or complications. For very tight

esophageal strictures, the authors replaced the guide wire through the tight stricture into the lumen initially dilated without complications. The ability of patients after 1 or more sessions of dilatation to maintain a solid or semisolid diet for more than 12 mo was obtained in 70 patients (95.8%). All patients with very tight strictures had clinical improvement but the authors noted 3 endoscopic dilatation failures (2 patients with anastomotic stricture and 1 patient with radicle stenosis).

Applications

The study suggests that dilatation with Savary-Gilliard dilators without fluoroscopy is effective and safe in esophageal benign strictures, especially peptic injury, Plummer-Vinson web and caustic injury.

Terminology

Savary-Gilliard dilators are polyvinyl dilators with progressive diameter (5-21).

Peer review

This is a good descriptive study in which the authors report the causes of esophageal benign strictures and analyze the effectiveness and safety of Savary-Gilliard dilatation without fluoroscopy.

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Does a melatonin supplement alter the course of gastro-esophageal reflux disease?

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TO THE EDITOR

I read with interest the paper by de Oliveira Torres and de Souza Pereira discussing the role of melatonin in gastro-esophageal reflux disease (GERD)^[1]. In 2006, Professor de Souza Pereira reported that melatonin may be a relevant therapy for GERD and published a comparison of the action of a melatonin combination formula and omeprazole in GERD therapy^[2,3].

Symptomatic GERD is an extremely common disease. It is estimated that approximately one-third of the United States population has GERD^[4]. The consequence of GERD is not only erosive esophagitis but also esophageal stricture, Barrett's esophagus and extra-esophageal damage (including the lungs, throat, sinuses, middle ears and teeth). GERD and Barrett's esophagus are identified as major risk factors for esophageal carcinoma. Besides acid reflux, bile reflux can be a clinical challenge due to refractory GERD and it may also play an important role in the progression from Barrett's to adenocarcinoma^[5,6].

It is worth drawing attention to studies performed on animal models by Konturek *et al*^[7]. They showed that therapy with melatonin prevents esophageal injury in cases of both acid-pepsin and acid-pepsin-bile exposure. Their study demonstrates that melatonin can be considered as a novel esophagoprotector by acting through cyclo-oxygenase, prostaglandins and nitric oxide synthase and also activation of capsaicin-sensitive afferent neurons, which contribute to mucosal protection^[7]. Konturek *et al*^[7] suggested that melatonin protection of the esophageal mucosa against acid-pepsin-bile occurs via its vasodilating effect on the esophageal microcirculation.

Although GERD pathophysiology is multifactorial, so far transient lower esophageal sphincter relaxation (TLESR) is commonly recognised as the predominant

Abstract

Symptomatic gastro-esophageal reflux disease (GERD) is a very common disease. The consequence of GERD is not only erosive esophagitis, but also esophageal stricture, Barrett's esophagus and extra-esophageal damage (including the lungs, throat, sinuses, middle ear and teeth). GERD and Barrett's esophagus are also identified as major risk factors for esophageal carcinoma. Therapy with melatonin prevents esophageal injury from acid-pepsin and acid-pepsin-bile exposure in animals, then further studies are required in humans to establish whether a melatonin supplement is able to protect the patients with GERD from erosions, Barrett's and neoplasia.

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Key words: Gastro-esophageal reflux disease; Melatonin; Chemoprotection; Barrett's

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Madalinski MH. Does a melatonin supplement alter the course of gastro-esophageal reflux disease? *World J Gastrointest Phar-*

mechanism^[8]. Many investigators agree that patients with GERD may experience an increase in esophageal mucosa acid exposure compared to control groups but there are patients where the number of TLESR is not increased compared to healthy controls^[8]. Therefore, a hypothesis with melatonin is interesting. Moreover, it may be reinforced by the fact that older people are at a higher risk of complications from persistent GERD and melatonin production decreases as a person ages^[9].

However, even if melatonin is really at the root of GERD pathophysiology, we cannot, at this stage, be sure if this hormone supplementation makes a viable substitution for proton pump inhibitor for healing erosive GERD. I think there is a no less interesting further point: if melatonin prevents esophageal injury from acid and alkaline reflux in animals, then further studies are required in humans to establish whether a melatonin supplement is able to protect patients with GERD from erosions and Barrett's esophagus from developing neoplasia. The results may also play an economic role for older patients who are at a higher risk of complications from persistent GERD and its therapy.

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Events Calendar 2011

January 14-15, 2011

AGA Clinical Congress of
Gastroenterology and Hepatology:
Best Practices in 2011, Loews Miami
Beach Hotel, Miami, FL,
United States

January 27, 2011

Symposium of the Swiss Society
of Pharmacology and Toxicology,
Advances in Pharmacology-
Psychopharmacology, Bern,
Switzerland

February 17-20, 2011

APASL 2011 - The 21st Conference
of the Asian Pacific Association for
the Study of the Liver, Bangkok,
Thailand

February 26-March 01, 2011

Canadian Digestive Diseases Week,
Westin Bayshore, Vancouver, British
Columbia, Canada

March 02-05, 2011

American Society for Clinical

Pharmacology and Therapeutics
2011 Annual Meeting, Dallas, TX,
United States

March 22-24, 2011

11th South East Asian Western
Pacific Regional Meeting of
Pharmacologists in conjunction
with the 84th Annual Meeting of the
Japanese Pharmacological Society,
Yokohama, Japan

March 24, 2011

Asia Pharma R&D Leaders 2011-the
largest and premier pharma R&D
summit in China, Shanghai, China

April 06-08, 2011

Third Latin American Symposium
on Gastrointestinal Oncology -
Chilean Foundation for Oncology
Development Joint Symposium,
Vina Del Mar, Chile

April 20-23, 2011

9th International Gastric Cancer
Congress, COEX, World Trade
Center, Samseong-dong, Gangnam-
gu, Seoul 135-731, South Korea

May 22-25, 2011

2011 American Academy of
Veterinary Pharmacology &
Therapeutics 17th Biennial
Symposium, 610 Langdon Street,
Madison, WI, United States

May 24-27, 2011

Meeting joint between CSPT and the
Canadian Society for Pharmaceutical
Sciences, the Controlled Release
Society and the Natural Health
Products Research Society of
Canada, Montreal, Quebec, Canada

June 26-29, 2011

10th European Association for
Clinical Pharmacology and
Therapeutics Congress, Budapest,
Hungary

September 11-13, 2011

40th Annual Meeting of American
College of Clinical Pharmacology,
Crowne Plaza Chicago O'Hare
Hotel, Chicago, IL, United States

October 02-06, 2011

12th International Congress of
Therapeutic Drug Monitoring

& Clinical Toxicology, Stuttgart,
Germany

October 06-07, 2011

IV InterAmerican Oncology
Conference: Current Status and
Future of Anti-Cancer Targeted
Therapies, Buenos Aires, Argentina

November 11-12, 2011

Falk Symposium 180, IBD 2011:
Progress and Future for Lifelong
Management, 1-12-33 Akasaka,
Minato-ku, Tokyo 107-0052, Japan

December 01-04, 2011

International Symposium On Ocular
Pharmacology And Therapeutics,
Hilton Vienna, Vienna, Austria

December 04-07, 2011

Perth 2011 joint Meeting between
the Australian Physiological Society,
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and Experimental Pharmacologists
and the High Blood Pressure
Research Council of Australia, Perth
Convention Centre, Perth. WA,
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INSTRUCTIONS TO AUTHORS

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There are unstructured abstracts (no more than 256 words) and structured abstracts (no more than 480). The specific requirements for structured abstracts are as follows:

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- 3 **Tian D**, Araki H, Stahl E, Bergelson J, Kreitman M. Signature of balancing selection in Arabidopsis. *Proc Natl Acad Sci USA* 2006; In press

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- 5 **Vallancien G**, Emberton M, Harving N, van Moorselaar RJ; Alf-One Study Group. Sexual dysfunction in 1, 274 European men suffering from lower urinary tract symptoms. *J Urol* 2003; **169**: 2257-2261 [PMID: 12771764 DOI:10.1097/01.ju.0000067940.76090.73]

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- 9 Outreach: Bringing HIV-positive individuals into care. *HRS-A Careaction* 2002; 1-6 [PMID: 12154804]

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- 11 **Lam SK**. Academic investigator's perspectives of medical treatment for peptic ulcer. In: Swabb EA, Azabo S. Ulcer disease: investigation and basis for therapy. New York: Marcel Dekker, 1991: 431-450

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Patent (list all authors)

- 16 **Pagedas AC**, inventor; Ancel Surgical R&D Inc., assignee. Flexible endoscopic grasping and cutting device and positioning tool assembly. United States patent US 20020103498. 2002 Aug 1

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Write as mean \pm SD or mean \pm SE.

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