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Schatzki's Ring Harboring Squamous Cell Carcinoma: A Case Report

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Purpose: Schatzki-Gary ring or esophageal B ring is an intraluminal circumferential mucosal fold that is found at the lower end of esophagus. It generally marks the squamo-columnar junction. It is fairly common and is found in 6-14% of routine barium studies. Usually it is considered benign and is treated as such. We present a case of food impaction due to a rare Schatzki Ring (SR) which turned out to be harboring squamous cell cancer. A 71 year old male presented to the ER with chief complaints of epigastric pressure and feeling of something stuck in his esophagus after he ate some roast beef. He was unable to eat or drink any further. He has a history of food impaction with SR 25 years ago, for which he had endoscopic dilation. Upper gastrointestinal endoscopy (UGIE) this time revealed ball of food impacted at the lower end of esophagus. Upon insufflation of esophagus, it passed freely into stomach revealing a SR with some ulceration. On follow up UGIE, biopsies were taken from the ring and the esophagus was dilated with a 54F Savary dilator. Biopsy revealed cellular atypia. Repeat UGIE showed nodularity in the SR without any ulceration. Biopsies from the nodularity showed squamous cell cancer. Endoscopic ultrasound showed benign appearing para esophageal lymph nodes. CT Thorax showed some distal esophageal thickening. PET scan showed no metastasis. Patient underwent esophagectomy by thoracic surgery. Pathology revealed moderately differentiated squamous cell cancer with muscularis mucosa invasion and negative lymph nodes (stage T1a N0 Mx).

Conclusion: SR is generally 2mm thick with squamous epithelium on its superior surface and columnar epithelium on its inferior surface. It is the third most common cause of esophageal type dysphagia after esophageal stricture, esophagitis/ulcer. It is mostly associated with hiatal hernia and GERD. It can cause food impaction when its internal diameter is less than 13mm. Full column barium esophagography is more sensitive than UGIE for the diagnosis. Treatment is by UGIE and dilation with a large (50F) dilator or balloon dilator and endoscopic electro-cautery incision for recurrent ones. Recurrence rate after dilation is high with 30% of them requiring repeat dilation within one year. Recurrence can be decreased by combining Endoscopic dilation with PPI therapy and using endoscopic incision for the second dilation. To our knowledge, SR was never reported to harbor malignancy. For this reason, general consensus during its dilation is not to biopsy the SR. But since it forms the squamo-columnar junction, under appropriate case setting (presence of atypia and risk factors like history of smoking, etc.) SR, if present, malignant disease should not be automatically ruled out until careful examination has been done.

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Esophageal Hematoma Masquerading as a Food Bolus Impaction

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Purpose: Radiofrequency catheter ablation (RFA) for medically refractory atrial fibrillation is an increasingly common treatment to achieve sinus rhythm. Complications are rare and often associated with thermal injury in the setting of therapeutic anticoagulation. We present a case of an esophageal hematoma following RFA to treat atrial fibrillation. 81-year-old female with hypertension and medically refractory atrial fibrillation underwent successful RFA. She was discharged same day and was placed on amiodarone and dabigatran. Seventeen days following discharge, she developed the acute onset of sharp, substernal chest pain with radiation to her back along with dysphagia to cold liquids. Emergency medical services (EMS) was called and she was taken to a local hospital. A CT angiogram was performed to exclude an aortic abdominal aneurysm which incidentally noted edema and debris within the esophageal lumen concerning for a food bolus impaction. Upon transfer to our facility, glucagon was administered without benefit. An upper endoscopy was performed that demonstrated extrinsic compression of the middle and

lower third of her esophagus and gastric cardia along with a small gastric ulcer with a clean base and clotted blood throughout the gastric body. Considering her recent electrophysiology intervention, there was immediate concern for a large esophageal hematoma due to her recent RFA. A repeat CT of chest was notable for a large hematoma measuring 2.4 cm × 2.6 cm in axial diameter that spanned a craniocaudal length of 13 cm. The proximal extent was mid esophagus at the carinal bifurcation and extended to the gastroesophageal junction. No extravasation of contrast noted. Her dabigatran was discontinued and thoracic surgery was consulted and recommended conservative management. The patient was discharged on day 7 in stable condition. A repeat upper endoscopy was performed 3 months later which demonstrated complete resolution of the previous submucosal hematoma. Esophageal hematomas are rare. They rarely lead to hemodynamic instability but can cause compression of the left atrium in addition to significant blood loss. In the absence of hemodynamic instability, conservative management including cessation of anticoagulation is recommended. Despite multiple safety measures, esophageal injury has been estimated to occur in approximately 2.9% of patients undergoing RFA. Esophageal hematomas should always be considered in the setting of acute dysphagia and RFA.

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Esophageal Obstruction after Variceal Banding, Report of a Rare Complication

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Purpose: Endoscopic band ligation (EBL) is the treatment of choice for bleeding esophageal varices. EBL is also an accepted practice for both primary and secondary prophylaxis in the setting of end stage liver disease (ESLD). Well-known complications from band ligation include gastrointestinal bleeding, band ulceration and transient dysphagia. Esophageal obstruction, however, is rarely reported.

Methods: A clinical vignette case report is presented.

Results: A 78-year-old woman with ESLD secondary to nonalcoholic steatohepatitis complicated by hepatocellular carcinoma was undergoing routine endoscopic band ligation of large esophageal varices for primary prophylaxis. She had successfully tolerated two prior band ligations without complications. During her most recent upper endoscopy, she was noted to have two columns of distal esophageal varices. She had no evidence of band ulcerations, rings or stricturing of her entire esophagus. Two bands were successfully placed with complete eradication of the distal varices. She did well post-procedure except for a mild sore throat which improved with viscous lidocaine. The next day, she presented to the emergency department with dysphagia, odynophagia and difficulty tolerating her secretions. She underwent a repeat endoscopy with a miniature endoscope which showed complete obstruction of the distal esophagus by the prior banded varix. She was kept NPO and underwent esophageal dilatation three days later with improvement in her symptoms. Her symptoms resolved completely after two weeks.

Conclusion: Esophageal obstruction is a rare complication of endoscopic band ligation. Previously reported cases presented with symptoms of obstruction immediately after the procedure. This case highlights that obstruction can be delayed and was likely due to edema of the varix after band ligation.

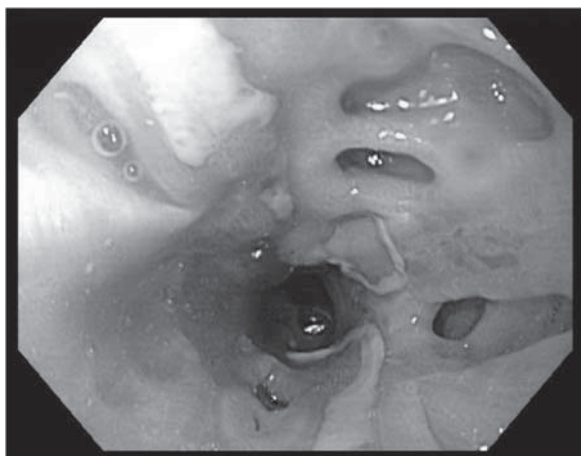
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Unusual Presentation of Barrett's Esophagus and Erosive Esophagitis with Esophageal Diverticula

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Purpose: We present a case of mid-esophageal diverticulosis associated with erosive esophagitis, Barrett's esophagus (BE) and solid food dysphagia.

A 62-year-old man presented to clinic with longstanding typical symptoms of GERD and dysphagia without weight loss. He endorsed solid food predominant dysphagia and intermittent obstructive symptoms relieved by emesis but denied dysphagia to liquids or odynophagia. The physical exam was unremarkable. EGD was performed and showed several mid-esophageal diverticula associated with severe esophagitis and mild stricture formation of the mid-esophagus (32-34 cm) (Figure 1). Mucosal biopsies and cytology brushings remained negative for malignancy and demonstrated BE. A barium swallow revealed narrowing at the mid-esophagus, proximal dilation, and multiple sinus tracts (Figure 2) without mucosal irregularities. Furthermore, EUS revealed intact, thickened muscularis propria of the mid-esophagus and benign appearing enlarged lymphnodes; confocal imaging showed some atypical features, and CT thorax showed esophageal wall thickening without evidence of malignancy. The patient was commenced on PPI therapy and had complete symptom resolution. Mucosal healing with persistence of mid-esophageal diverticulosis was demonstrated in follow up EGD. This rare case of mid-esophageal diverticula may have been caused by chronic erosive esophagitis and BE with increased intraluminal pressure. Multiple imaging modalities, including EUS and confocal imaging were used for the first time in this unique case.



[572] EGD image of midesophagus.



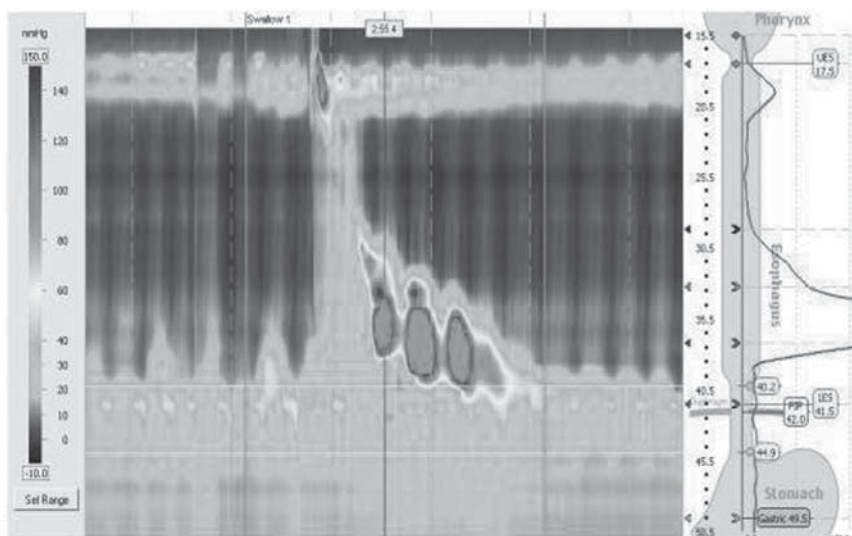
[572] Barium swallow.

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An Uncommon Cause of Food Impaction

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Purpose: Esophageal food impaction is usually secondary to structural abnormalities of the esophagus such as Schatzki's ring, eosinophilic esophagitis or



[573] High resolution manometry showing hypertensive peristaltic waves in the distal esophagus.

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