

LETTER TO THE EDITOR



Migration of an Esophageal Stent to the Trachea

To the Editor: Esophageal carcinoma has a mortality rate of 90% after 5 years. Total resection can only be performed in 40% of cases and the 5-year survival rate after the procedure is less than 20%. One contraindication for curative surgery is invasion of the respiratory tract with the appearance of esophagobronchial or esophagotracheal fistulas.^{1,2} The incidence of these fistulas ranges from 10% to 15%; life expectancy is less than 7 weeks if they are left untreated.^{1,3,4}

We present the case of a 49-year-old male alcoholic, an ex-smoker of 50 pack-years, who was diagnosed with poorly differentiated stage-IV cancer of the esophagus with multiple metastases to the lung and liver. The patient attended the emergency department of our hospital due to difficulty breathing. Esophagogastric transit gave evidence of a fistula between the esophagus and the airway 2 cm from the tracheal carina. A self-expanding metallic stent was placed in the esophagus with good immediate results. The patient returned a month later with progressive dyspnea and dysphagia. Gastroscopy revealed that the stent had migrated to the stomach and a new stent was therefore inserted. The patient returned 3 months later with respiratory failure. A chest x-ray revealed signs of bronchial aspiration. Bronchoscopy showed the metallic esophageal stent in the upper trachea, with a large tracheoesophageal fistula 3 cm from the vocal chords (Figure).



Figure. Esophageal stent that has migrated to the trachea.

The patient died some days after the examination, before the fistula could be treated effectively.

Esophagotracheal fistulas tend to appear in very advanced stages of esophageal cancer, when corrective surgery is no longer indicated.^{1,2} The patient presented cough, difficulty breathing, repeated episodes of bronchial aspiration, recurrent pneumonia, intolerance to food taken by mouth, and weight loss.^{1,2} Palliative treatment consists of placing a stent in the trachea, the esophagus, or both.⁵ Self-expanding metallic stents are most commonly used as they are associated with a lower rate of complications.¹⁻⁵ Placement of the stent achieves complete closure of the fistula in approximately 80% of cases,¹ though complications are not unknown. These include persistent chest pain, necrosis of the tracheal or esophageal mucosa due to pressure, formation of granulation tissue leading to stenosis,

dyspnea due to compression of the trachea, perforation, hemorrhage (which may manifest as hemoptysis or hematemesis), and migration of the stent. Migration occurs in 5% to 15% of cases¹⁻³ and requires that the stent be replaced.^{1,5}

In our patient, the implanted esophageal stent migrated on 2 occasions. The first time, it moved to the stomach a month after insertion and was replaced. The second esophageal stent migrated to the trachea through a large esophagotracheal fistula after 3 months. The patient died of respiratory failure during an episode of bronchial aspiration, before the migrated esophageal stent could be replaced.

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