



Clinical Image

Triple stent placement for tracheoesophageal fistula closure[☆]

Colocación de triple prótesis para cierre de fístula traqueoesofágica

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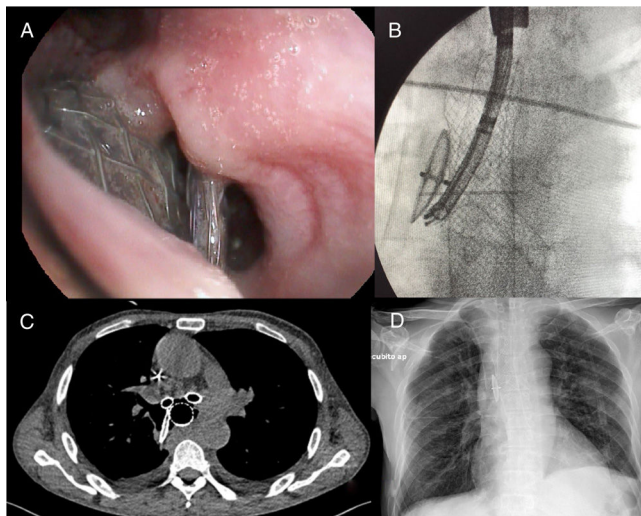


Fig. 1. A) Flexible bronchoscopy view showing a continuity defect in the posterior wall of the distal third of the trachea, with visualization of esophageal stents and atrial septal defect occluder. B) Fluoroscopic view of the 3 normally positioned stents by flexible bronchoscopy through rigid bronchoscope. C) Chest CT image without intravenous contrast, axial plane, lung window showing the presence of the 3 devices used for closing the fistula. D) Plain post-anterior chest X-ray after intervention showing correct positioning of the 3 implanted devices.

We report the case of a 54-year-old male diagnosed in November 2018 with esophageal cancer with mediastinal involvement and histology consistent with epidermoid carcinoma. The mass caused esophageal stenosis, manifested clinically as difficulty swal-

lowing liquids, excessive salivation, and aspiration pneumonia in the right lower lobe. A 32 × 210 mm self-expanding metal esophageal stent (SEMS) was placed (subsequently replaced due to intolerance with a 23 × 105 mm Wallflex[®] Fully Covered SEMS, Boston Scientific[®]) and an 35 mm Amplatzer[®] atrial septal defect occluder (Abbott[®]) was inserted due to loss of integrity of the distal third of the tracheal posterior wall. Given the lack of resolution of the clinical picture, flexible bronchoscopy was performed, which confirmed the presence of a large tracheal defect, with visualization of both previously implanted devices (Fig. 1A). An Aerstent[®] tracheal Y-stent with partial polyurethane coating (Leufen[®]) measuring 40 × 20 × 30 mm was implanted using fluoroscopy-guided rigid bronchoscopy without complications. Additional intra- and post-operative imaging tests showed correct positioning of the 3 devices (Fig. 1B, C, and D), while the patient's clinical situation improved.

Fistulas or communications between the airway and the esophagus are an uncommon complication of esophageal and pulmonary malignancies, and require a sequential and individualized endoscopic approach and the use of several devices aimed at improving patients' symptoms^{1,2}.

References

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