



Endoscopic esophageal septotomy

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An esophageal septum is an extremely rare endoscopic finding, generally associated with aggression of the mucosa caused by caustics, prolonged use of a nasogastric tube, or by esophageal reflux disease.¹⁻³ We report a case of esophageal septum in a 61-year-old patient who was evaluated because of 7 months of dysphagia.^{1,4}

PATIENT AND METHODS

A 61-year-old man with no history of morbidity had experienced progressive dysphagia and esophageal discomfort for 7 months. In this video case report (Video 1, available online at www.VideoGIE.org), we describe an esophageal septum 3 cm long, located 23 cm from the bite block (Fig. 1).

ENDOSCOPY PROCEDURE

When EGD was performed, the superior and inferior esophageal sphincters were seen to be located 18 cm and 40 cm, respectively, from the bite block. There was no evidence of hiatal hernia. At 23 cm from the bite block, we

observed an esophageal septum 3 cm long. Hemoclips were placed at the ends of the septum (Fig. 2). Particular care was taken to avoid the deeper esophageal walls. We proceeded to section the septum between the clips with a



Figure 2. Placement of hemoclips are placed at the ends of the septum. Particular care is taken to avoid deeper esophageal walls.

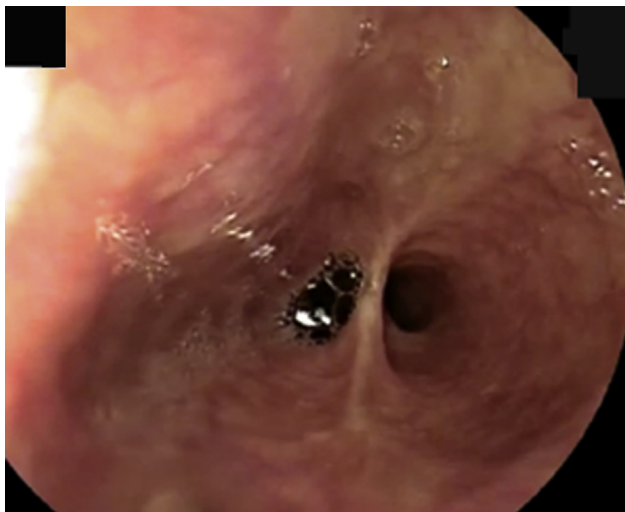


Figure 1. EGD in a 61-year-old man who had experienced dysphagia for 7 months without accompanying symptoms or comorbidities. EGD view shows, 23 cm from bite block, esophageal septum 3 cm long.

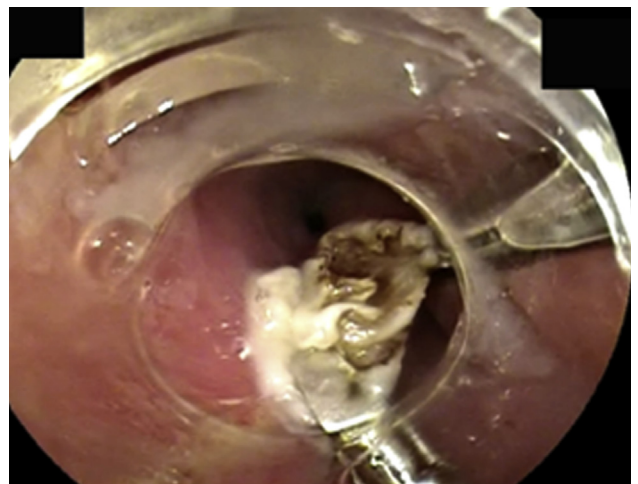


Figure 3. Septum is sectioned between the clips with flush knife. The placement of hemoclips in distal segments of the septum is repeated by repeating the section with the flush knife.

Written transcript of the video audio is available online at www.VideoGIE.org.

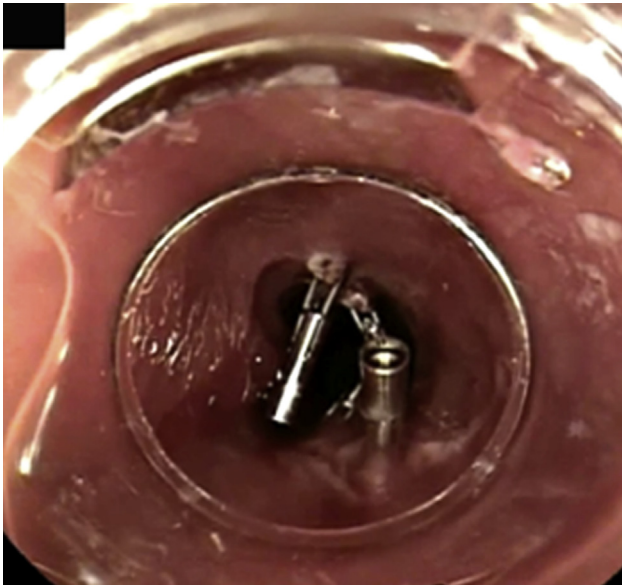


Figure 4. Hemostasis control and complete section of septum. The initial use of clips was done because high vascularization of the septum was suspected.

flush knife (Fig. 3). The placement of hemoclips in distal segments of the septum was done by repeating the section with the flush knife with hemostasis control and complete septum section (Fig. 4). The initial use of clips was done because high vascularization of the septum was suspected, and it was thought that the clips would prevent any bleeding that would have complicated the procedure. However, the use of clips hindered sectioning of the septum by obstructing the section line, so we discontinued using them, and no bleeding occurred. Analyzing the case retrospectively, we concluded that the use of clips was unnecessary. The patient had a favorable response to the procedure and was discharged 12 hours afterward.

CONCLUSION

In this case, there was no history of ingestion of caustic material or other type of injury.³⁻⁵ The patient's immediate progress after the procedure was optimal, without adverse events, which implies that this procedure is safe and can be performed on an outpatient basis. After 7 months of follow-up, the patient continues to be asymptomatic.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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