

Surgical Stenosis of the Oesophagus

By R. M. VERSTEEGH

The oesophagus belongs to the organs that have offered resistance to surgical treatment up to the very last. Only since a few years has it been possible to treat operatively—with a reasonable chance of success—various diseases of the oesophagus which so far had remained incurable or at most liable to symptomatic treatment. It is therefore fully understandable that the indications for operation have greatly increased in extent. For example, many patients with benign oesophageal stenosis, who formerly were treated by bouginage, are nowadays subjected to operation. Without doubt this not only leads to a considerable shortening of the treatment in many cases, but it also reduces the risks of the treatment, for in every bouginage there is always the latent possibility that the sound takes a wrong route.

There are three possibilities of surgical treatment of oesophageal stenosis:

1) In the case of a very short stenosis, the constriction may be incised longitudinally, following which this incision is transversely sutured;

2) In the case of a somewhat longer stenosis, the constriction may be excised as a whole, followed by an end-to-end anastomosis of the two parts of the oesophagus. However, in this way only relatively short stenoses can be treated, for the chance of leakage and re-stenosis is greater the higher the tension on the anastomosis;

3) If the segment to be excised is so great that an end-to-end anastomosis is no longer possible, resection is indicated; in this case, the gap left by the resected segment has to be overbridged in one way or another. Resection of a part of the oesophagus, followed by drawing up of the stomach into the thorax, has

proved not to be the right method. If the function of the cardia, whatever this may be, is disturbed, a reflux from the stomach occurs. This leads to a peptic oesophagitis, often followed by a new stenosis. The only correct method of operation in these cases is interposition of an intestinal loop between the stump of the oesophagus and the stomach.

However, surgical treatment may also give rise to great difficulties. Post-operatively, a suture stenosis develops at the site of the anastomosis in about 25% of cases; this must be treated by dilatation with probe. This treatment may sometimes be severely impeded, because scar retraction may cause a kink at the site of the anastomosis, which results in a very great chance of perforation.

Treatment of surgical stenosis of the oesophagus should proceed along the lines of conduct known from oesophageal stenosis after lye corrosions. This implies, that dilatation should be started early, before the stenosis has become serious. Two weeks post-operatively, a contrast photograph of the oesophagus must be made, in order to begin bouginage even at the very first signs of constriction of the anastomosis. This bouginage should be kept up for at least a year, of course with steadily increasing intervals, because a stenosis may recur even after a year. The various difficulties met with in the treatment of surgical stenosis are demonstrated on three patients, in one of whom oesophageal resection with interposition of an intestinal loop had been carried out because of extensive constrictions after the drinking of hydrochloric acid, in the other two an anastomosis had been made for a congenital oesophageal atresia.

Author's address: Dr. R. M. Versteegh, Wilhelminapark 33, *Utrecht* (Netherlands).
