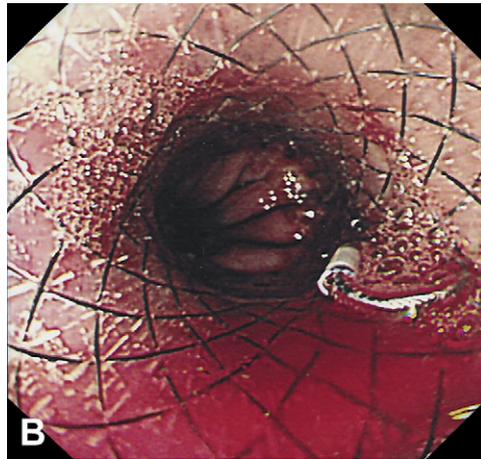
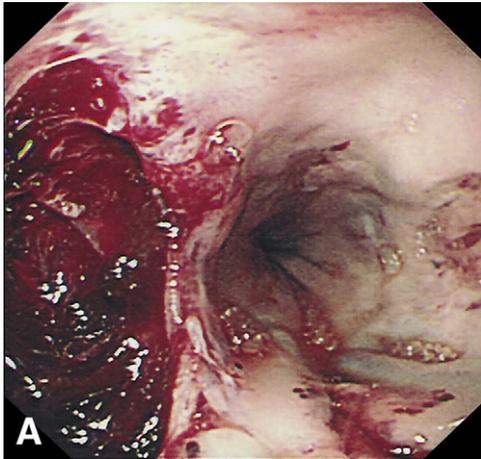


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A removable covered self-expanding metal stent for the management of Sengstaken-Blakemore tube-induced esophageal tear and variceal hemorrhage



A 44-year-old man with known alcoholic cirrhosis was referred after failed endoscopic therapy of esophageal variceal hemorrhage in his local hospital. A Sengstaken-Blakemore tube (SBT) had been inserted with some difficulty before intubation and transfer to our unit. Repeat endoscopy revealed a long (28 to 40 cm from the mouth) esophageal tear (**A**), presumably from an unrecognized intraesophageal SBT-gastric balloon-inflation. The stomach contained blood, and the esophageal varices were seen to be oozing. A removable polyurethane membrane-covered self-expanding metal stent (SX-ELLA stent Danis, 135 mm × 25 mm, ELLA-CS, Hradec-Kralove, Czech Republic) was inserted in the patient in the intensive care unit to prevent further portal hypertensive bleeding and to close the esophageal tear (**B**). A transjugular intrahepatic portosystemic shunt was successfully performed 36 hours later, when coronary vein feeding vessels were coil embolized (**C**). The patient was extubated the following day. A CTscan showed the esophageal tear with mediastinal air and a left-sided pleural effusion (**D**). Seven days after deployment, the esophageal stent

was removed endoscopically under fluoroscopy, and a nasogastric tube was inserted. Total parenteral nutrition was started. After a normal iohexol-swallow study, oral intake was reintroduced 11 days after stent removal. The patient was discharged 2 days later and has remained well.

DISCLOSURE

The authors report that there are no disclosures relevant to this publication.

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Commentary

The Sengstaken-Blakemore tube, once considered the standard therapy for bleeding esophageal varices, has long since clinched its current position as the least-preferred method of treatment—in large measure, and as illustrated in the current case, because of its high complication rate. Indeed, today's fellows-in-training might not have even heard of the tube, and gastroenterologists in practice for only 2 decades or less may not have had the early-morning adventure of actually using it to stanch hemorrhage. I always found the most interesting part of its placement to be the means chosen to apply traction to the tube: a system of weights strung over a bed pulley and attached to the tube which, in turn, was anchored in place by a football helmet the patient wore as a somewhat comical but foreboding badge of courage. Self-expanding metal stents rarely have been used to tamponade variceal hemorrhage and also have been used to allow esophageal rents to heal. In the current case, we have an economy of purpose: not only did the stent expand, but its justification also expanded to accommodate both indications in one unfortunate individual.

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