

## **“TO STUDY THE OUTCOME OF GASTRIC PULLUP SURGERYIN CASES WITH ESOPHAGEAL STRICTURE DUE TO CORROSIVE POISONING”**

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### **ABSTRACT**

**INTRODUCTION:** *Post corrosive late complications are a major concern in corrosive poisoning, most common being esophageal stricture and stenosis, gastric stenosis of the antrum and pylorus and esophageal and stomach cancers. In this article, we present our surgical experience regarding the outcome of management of corrosive esophageal stricture by gastric pulls up followed by esophagogastrostomy.*

**MATERIALS AND METHODS:** *A total of 4 patients were studied, 3 females and 01 male. All the patients had a stricture in the cervical region of the esophagus and operated 6 months after the initial insult. Malignant etiology or gastric pathology was ruled out in all the 4 patients. Retrosternal approach with gastric tube formation was used in 2 patients and without the formation of a gastric tube in the other 2 patients. In all 4 patients, the anastomosis was done in the cervical region. A strictural segment of esophagus was not removed in any of the patients. In the pre-op period, 3 patients were on feeding jejunostomy and 1 on nasogastric tube feeding.*

**RESULT:** *of the 4 patients, 3 patients went uneventfully in the post-op period whereas 01 patient developed esophagocutaneous fistula, which was managed conservatively. 1 patient is in follow up for 1year, 1 patient for 6 months and 2 patients for 3 months. Patients were kept on a liquid and semi-solid diet in the post-op period and alternate route feeding (feeding jejunostomy/ nasogastric tube feed) was continued, although tapered gradually. No late complication has been reported so far.*

**CONCLUSION:** *Patients with corrosive esophageal strictures can be managed effectively with gastric pull up with esophagogastrostomy, with or without gastric tube formation. A retrosternal approach can be used safely, thereby avoiding complications arising from the transhiatal approach.*

**KEYWORDS:** *Esophageal Stroint Strictures, Gaestinal System, Management of Corrosive Esophageal Stricture*

### **INTRODUCTION**

Ingestion of caustic substances and its long term effects on the gastrointestinal system maintains its place as an important public health issue despite the multiple efforts to educate the masses about the same. The age of occurrence presents in bimodal fashion- first peak in 1 to 5 -year group, accidentally or out of curiosity, and a second peak ~21 years of age, due to the high frequency of suicides among the young. Traditionally, ingested corrosive agents are either alkalis or acids. Alkaline substances account for most caustic ingestions in western countries, whereas, injuries from acids is more common in developing countries like India. <sup>1</sup> **Clinically apparent esophageal**

strictures occur in 10-30% of patients with a caustic injury. Except for perforation or penetrating injury, emergency surgical exploration is contraindicated., **Post injury, scar retraction begins at the end of the second week and lasts for about 6 months.** Hence, surgery for esophageal stricture is advisable only after 6 months following corrosive injury. Organs to be used for esophageal replacement include stomach, jejunum, and colon.<sup>2</sup> Stomach can be used with or without gastric tube formation. In our study, we present our surgical experience regarding the outcome of management of corrosive esophageal stricture by gastric pullup and esophagogastrostomy in the neck.

## **MATERIALS AND METHODS**

- Total of 4 patients was studied, 3 females and 1 male.
- All patients had a stricture in the upper and mid-thoracic esophagus.
- All patients were operated 6 months after the initial corrosive insult.
- Malignant etiology and gastric pathology were ruled out in all patients.
- A retrosternal approach was used in all patients.
- In all 4 patients, side to side anastomosis was done in the cervical region. Gastric tube was made in two patients.
- Scarred, the residual esophagus was not resected in any of the patients.
- In the pre-op period, 3 patients were on feeding jejunostomy, and one on 1 nasogastric tube feeding.

## **RESULTS**

- 2 patients were uneventful in the post-op period.
- 1 patient developed esophagocutaneous fistula, which was managed conservatively.
- 1 patient developed a minor anastomotic leak, which was managed conservatively.
- There have not been any late complications.

## **CONCLUSIONS**

- Patients with a corrosive esophageal stricture in the cervical region could be managed effectively using the stomach as a conduit with esophagogastrostomy, with or without gastric tube formation.
- A retrosternal approach could be used safely thereby avoiding complications arising from transhiatal approach, without compromising the quality of life.
- Residual scarred esophagus need not be removed since it predisposes to injury to adjoining structures.

## **REFERENCES**

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