Case No. 7

Male - age: 52

Medical History

- Past pleuro-pulmonary events.
- Abuse of wine and alcohol for about 15 years.
- Alcoholic polyneuropathy and dysphagia due to esophageal stenosis.

Disease onset

- Total dysphagia
- Reflux
- Salivation
- Weight loss
- Asthenia

Physical examination

- Cachexia
- Dehydration
- Pallor
- Muscular atony and atrophy
- Lingual dysepithelization
- Hepatomegaly
- Mild epigastric pain

Diagnostic examination

- Anemia
- Hypoproteinemia
- Ionic disorders
- Standard X-ray (Rx) and computerized tomography (CT) show long organic stenosis of the esophagus (middle-lower thirds) and ectasia of upper third (Fig.1).
- Endoscopy confirms this features, without signs of cancer (biopsy).

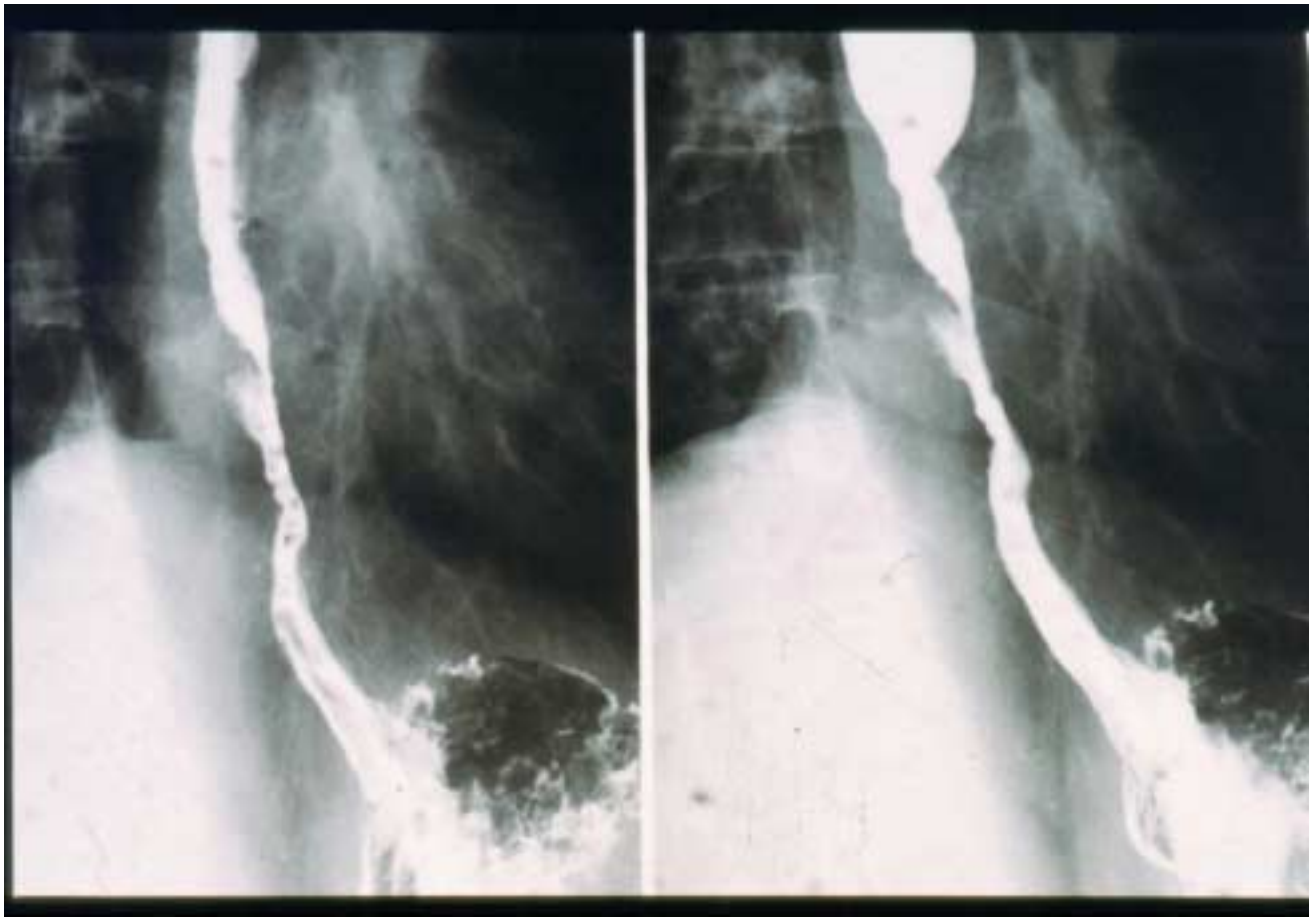

Fig. 1

Diagnosis: long cicatricial esophageal stricture

After parenteral nutrition treatment (PNT/60 days), surgery is decided: total esophagectomy.

Surgical procedure

1° - video-thoracoscopy (**see video**)

Left side decubitus. Three trocars (10 mm) + 2 trocars (12 mm): V - III intercostal space (IS) on anterior axillary line (AL); VIII - IV IS on posterior AL; VI IS on median AL.

Difficult access due to diffuse pleural adhesions.

Identification of the esophagus by transillumination (esophagoscope).

Incision of the mediastinal pleura; section of azygos vein (GIA30); dissection and cutting (GIA at the thoraco-cervical junction) of the esophagus.

Re-expansion of the lung; control of air leaks by physiologic solution flooding; tubular drainage; suture.

2° - Laparotomy

Patient in supine position; median laparotomy.

Esophagus is drawn into the abdomen and the esophageal hiatus sutured.

Mobilization of the duodenum by Kocher's maneuver, anterior pylorectomy (Holle), preparation of the gastric tubule. Removal of the esophagus together with the cardial cone.

3° - Cervicotomy

Transverse cervicotomy; retrieval of the proximal esophageal stump.

Substernal *pull-through* of the gastric tubule; resection of the cervical esophagus; esophago-gastric (tubule) end-to-side anastomosis (manual).

Tubular drainage, Suture.

(Iconography: see Synopsis - neoplastic esophagus)

4° - Conclusion of the laparotomic procedure

Control of the hemostasis and toilet of the peritoneal cavity; suture of the abdominal wall.

Anatomopathology

Gross examination confirmed long esophageal stricture with wall thickening, phlogistic and ulcerative lesions. Microscopic examination confirmed these features and excluded neoplastic growth.

The **postoperative course** was regular and the patient was discharged on the 20th postoperative day.

Followed up for ten years, the patient was assisted to abstain from alcoholic beverages and to resume a normal working activity.

Remarks

A long cicatricial stricture of the esophagus due to alcohol abuse is rare and is not reported in the literature. The lesion observed here seems to bear more of a similarity to those resulting from the ingestion of a caustic agent, but this event is nowhere to be found in the patient's medical history. Reflux esophagitis could be responsible for the stenosis, but the condition is not borne out by the patient's specific symptoms; on the other hand, in case of the gastro-esophageal reflux disease, the stenosis is usually limited, not as long as was seen in this case.

Still another consideration is that the long-term alcoholic poisoning did not lead to the normally associated lesions of the liver and/or the central nervous system. This fact presumably allowed the surgical intervention described above, which was well tolerated and guaranteed a speedy and satisfying outcome.
