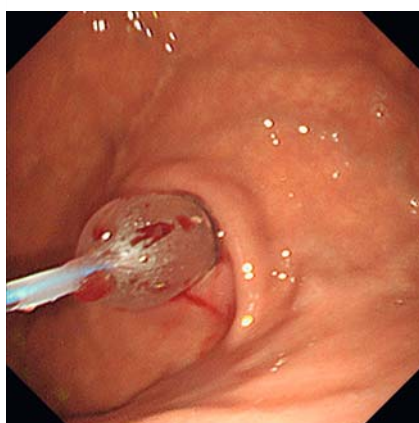


Retrograde esophageal endoscopic submucosal dissection through a gastrostomy



► **Fig. 1** Retrograde esophageal endoscopic submucosal dissection through a gastrostomy.

A 74-year-old man complained of trismus and was diagnosed with advanced pharyngeal cancer. A preoperative ultrathin endoscopy detected a superficial esophageal tumor, 30 mm in diameter, at the upper thoracic esophagus.

The patient followed a liquid diet completely owing to his restricted mouth opening. Consequently, a percutaneous endoscopic gastrostomy was performed to ensure sufficient nutrition. Chemoradiotherapy was directed toward the pharyngeal cancer and not the esophageal cancer to avoid a larger radiation field leading to complications. However, trismus persisted even after chemoradiotherapy, following which endoscopic submucosal dissection (ESD) was planned for the esophageal cancer.

First, balloon dilation was performed under vision by transnasal endoscopy (► **Fig. 1**). An endoscope (8.9 mm diameter, GIF-H290; Olympus, Tokyo, Japan) was inserted through the gastrostomy (► **Video 1**), and the tip of the transnasal endoscope was positioned just below the esophagogastric junction (► **Fig. 2**). We then proceeded with endoscopy to the esophageal lumen, and a circumferential marking was made (► **Fig. 3**). After making an oral mucosal incision using the



► **Video 1** Retrograde esophageal endoscopic submucosal dissection through a gastrostomy.



► **Fig. 2** The tip of the transnasal endoscope was positioned just below the esophagogastric junction, identified by a conventional endoscope through the gastrostomy.

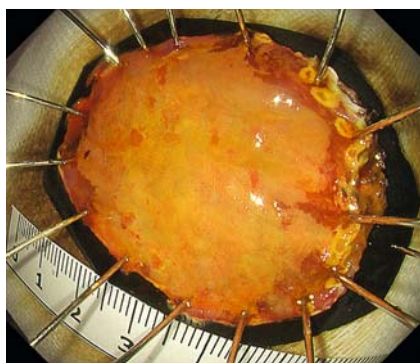


► **Fig. 3** Circumferential marking around the esophageal cancer was done.

endoscope through the gastrostomy, both circumferential incision and subsequent submucosal dissection were performed until the tumor was resected en bloc (► **Fig. 4**) using a clip with line attached to the anal side of the specimen and pulled through the gastrostomy for appropriate tension [1]. During the procedure, gas insufflated into the stomach was suctioned periodically to relieve the

patient's pain and prevent Mallory-Weiss syndrome, particularly when an ESD knife was placed in the esophageal lumen to make reinsertion into the esophageal lumen through the esophagogastric junction easier (► **Fig. 5**).

ESD using ultrathin endoscopy is reportedly useful [2,3]; however, endoscopic maneuverability is restricted. Moreover, the current device options are limited due to the availability of a small instrumentation channel. While a previous



► **Fig. 4** En bloc resection was achieved.



► **Fig. 5** While the gas insufflated into the stomach was suctioned, an endoscopic submucosal dissection knife was placed in the esophageal lumen to make reinsertion into the esophageal lumen through the esophagogastric junction easier.

case of gastric ESD via gastrotomy was reported [4], herein, by dilating the gastrotomy, we performed a successful retrograde esophageal ESD utilizing a conventional endoscope.

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Competing interests

The authors declare that they have no conflict of interest.

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