

Successful Treatment of a Persistent Esophageal Lichen Planus Stricture With a Fully Covered Metal Stent

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Abstract

We report a case of a 51-year-old woman with an esophageal lichen planus (ELP) stricture refractory to medical therapy and endoscopic stricture dilation. A multidisciplinary decision was made to place an esophageal fully covered metal stent. The stent was removed 6 weeks later and the patient is doing well on 3-month follow up. We show that a removable esophageal stent is an option after standard medical therapy and endoscopic dilations fail. This is the first reported use of an esophageal stent for therapy of an ELP stricture.

Introduction

Lichen planus (LP) is an autoimmune disease that affects squamous mucosa. Esophageal manifestations of LP are rare, and are seen in the proximal esophagus.^{1,2} One case series demonstrated that women accounted for 93% of cases of esophageal lichen planus (ELP).¹ There are no consensus guidelines on how to manage ELP.² Reported therapies in the literature include topical and systemic steroids, tacrolimus, and cyclosporine. Standard endoscopic therapies include stricture dilation and endoscopic injection of steroids into the stricture.^{2,3} Endoscopic mechanical dilation therapies are usually avoided unless conservative measures fail or the patient is highly symptomatic, as trauma can cause additional inflammation.²

Case Report

A 51-year-old woman with a history of biopsy-proven oral lichen planus (LP) presented with dysphagia. She had been placed empirically on a PPI when symptoms began. She underwent endoscopy that showed a 7-cm proximal, benign-appearing, friable esophageal stricture with superficial ulceration. Only a 4.9-mm diameter gastroscope could traverse the stricture. Extensive stricture biopsies were performed ruling out underlying neoplasm or esophageal eosinophilia, and a computed tomography (CT) scan was consistent with benign disease. Given the endoscopic and clinical findings were consistent with ELP, the patient was started on topical and then high-dose systemic steroids (prednisone 60 mg) for a total of 6 weeks.

The decision was made for endoscopic dilation given the patient was still symptomatic, losing weight, refractory to medical therapy, and refusing immunomodulator medications. She underwent 3 sessions of wire-guided, through-the-scope, balloon dilation to 10 mm under fluoroscopy with steroid injection into the stricture after dilation (triamcinolone 80 mg). Significant friability was observed after each dilation, and the stricture did not improve. (Figure 1).

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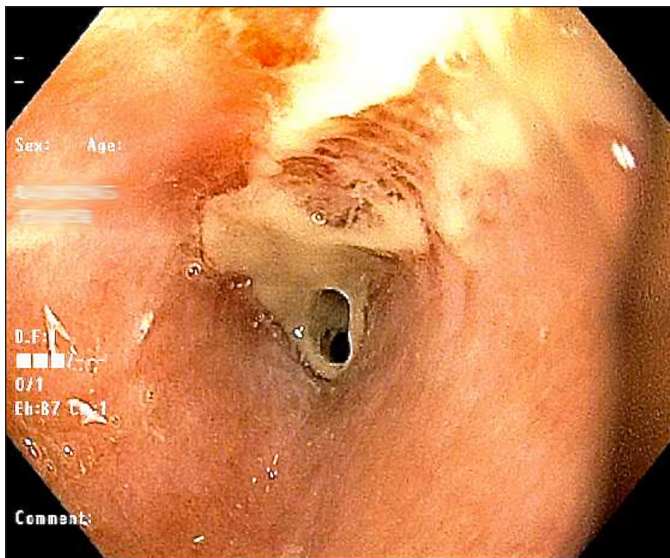


Figure 1. Persistent esophageal lichen planus stricture after medical therapy and 3 sessions of endoscopic dilation with injection of steroids into the stricture.

A multidisciplinary decision was made to place a removable esophageal fully covered metal stent (FCMS) while on steroids (to minimize inflammation from stent trauma). An 18 x 103 mm esophageal FCMS was placed (Figure 2). Six weeks later the stent was removed. The lesion had been successfully dilated and there was significant friability of the mucosa, as was expected for an ELP stricture (Figure 3). This degree of inflammation likely explains why the stricture was so refractory to prior medical and endoscopic management. At 3-month follow up, the patient was doing well without dysphagia while on maintenance steroids, with a slow taper planned. Repeat endoscopy was not performed at follow up given the absence of symptoms, but is planned in 1 year for surveillance given the associated risk of malignancy.⁴

Discussion

Less than 1% of patients with oral LP develop esophageal involvement. ELP is hard to characterize, but histologic features that may be present include: parakeratosis, acanthosis, apoptotic basal keratinocytes (Civatte bodies), and an inflammatory infiltrate.⁴ Most cases describe the characteristic friable and inflamed mucosa. Given the difficulty in diagnosis, it is important to exclude other causes of stricture including malignancy, eosinophilic esophagitis, candida, and peptic strictures. Malignancy, eosinophilic esophagitis, and candida can be excluded by biopsy. Peptic strictures involve the distal esophagus, while ELP usually involves the proximal esophagus. It can involve the distal esophagus, but spares the gastroesophageal junction.⁴

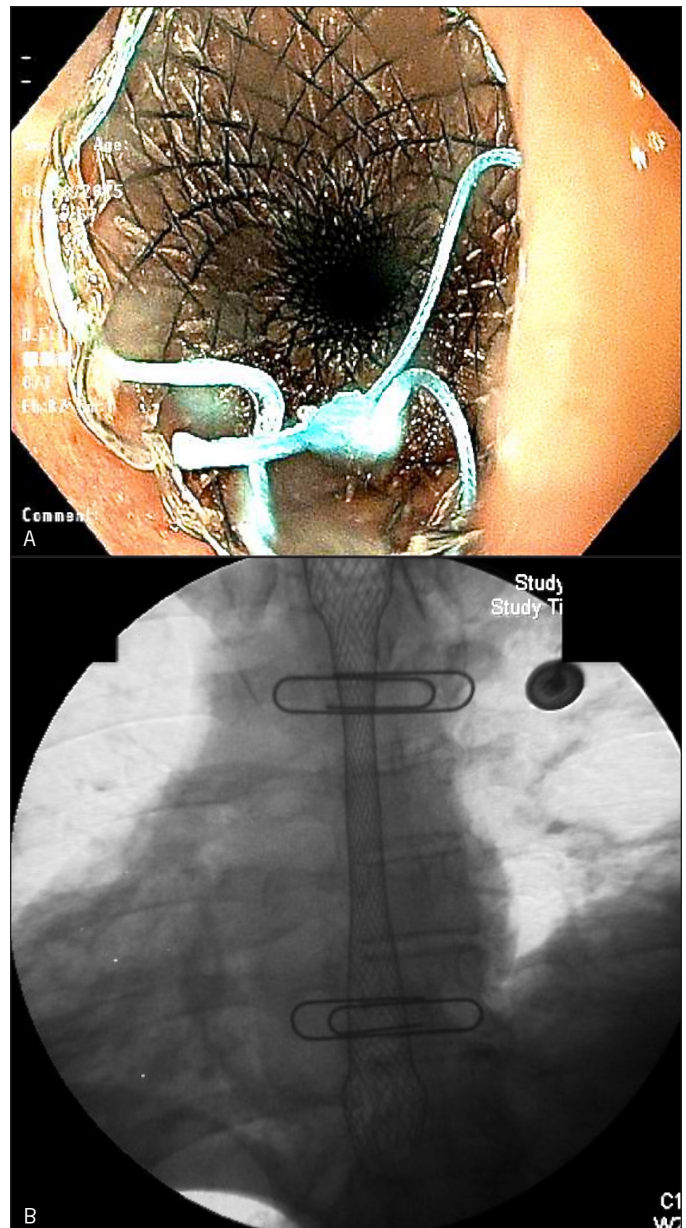


Figure 2. (A) Placement of a fully covered removable esophageal stent traversing the stricture. (B) Fluoroscopy of the esophageal stent after placement across the stricture.

To our knowledge, this is the first reported use of an esophageal FCMS for therapy of an ELP stricture. ELP should be on the differential diagnosis for dysphagia in a middle-aged woman. Conservative management with topical or systemic medications should be the first line in treatment of ELP. Endoscopic therapy can be successful for treatment of ELP, but should be reserved when standard measures fail or if a patient is highly symptomatic. We show that a FCMS is an option after standard medical therapy and endoscopic dilation fails.

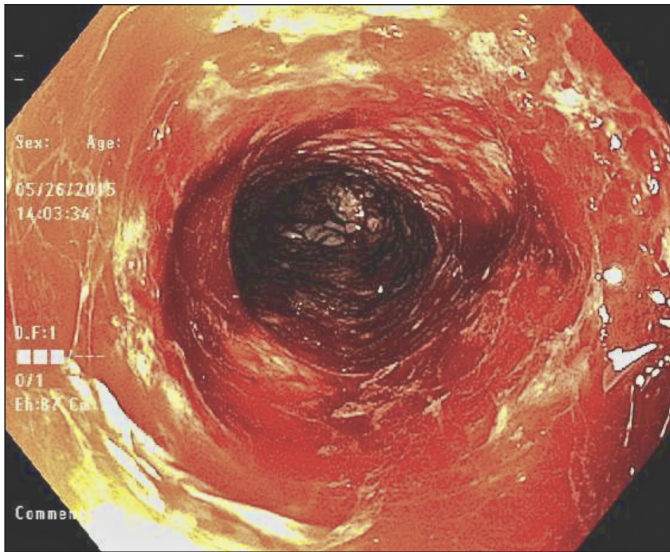


Figure 3. The esophagus in the area of the prior stricture after the stent removal. Note the significant erythema observed in the area of the prior stricture.

Disclosures

Author contributions: All authors contributed equally to manuscript writing, editing, and approval. AJ Trindade is the article guarantor.

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