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IMAGE | FUNCTIONAL GI DISORDERS

# An Unusual Case of Dysphagia

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## CASE REPORT

A 51-year-old man had a history of trauma resulting in an esophagectomy, creation of a colonic interposition, C7 quadriplegia, and autonomic dysreflexia. He presented to the hospital 4 years after his trauma with 2–3 weeks of progressive dysphagia to solids and liquids. He had associated nausea, chest pain, and dyspnea with swallowing. He denied gastrointestinal bleeding or a change in bowel habits. Physical examination was significant for bowel sounds in the left anterior chest; the abdominal examination was benign. Blood work was unremarkable aside from a mild normocytic anemia. Computed tomography scan demonstrated a markedly dilated, redundant colonic interposition in situ (Figure 1). Endoscopic evaluation of the colonic interposition found no strictures or obstruction and was notable only for retained food debris (Figure 2). The patient was started on a trial of prucalopride for his dysphagia and presumed dysmotility of the interposed segment while in hospital. At his 6-month follow-up, he had complete resolution of his dysphagia and other presenting symptoms. His bowel movement frequency was unchanged.

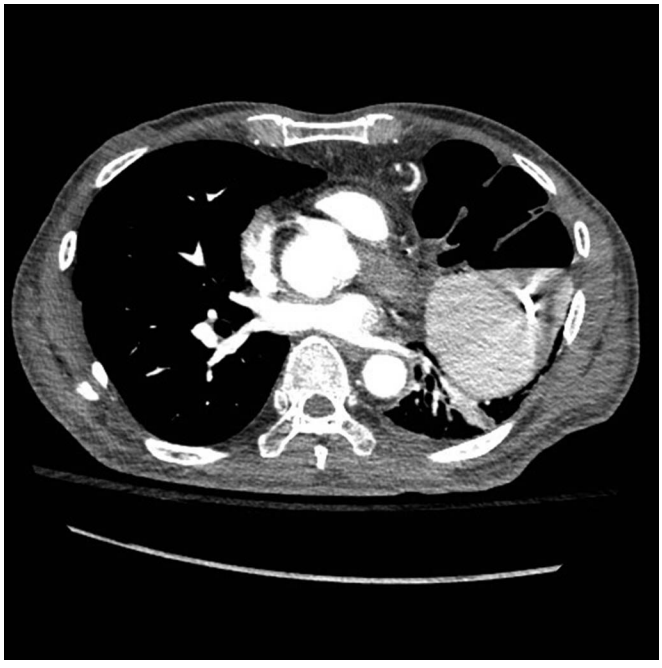

**Figure 1.** Thoracic computed tomography showing a markedly dilated colonic interposition. Note the haustra in the dilated interposition.

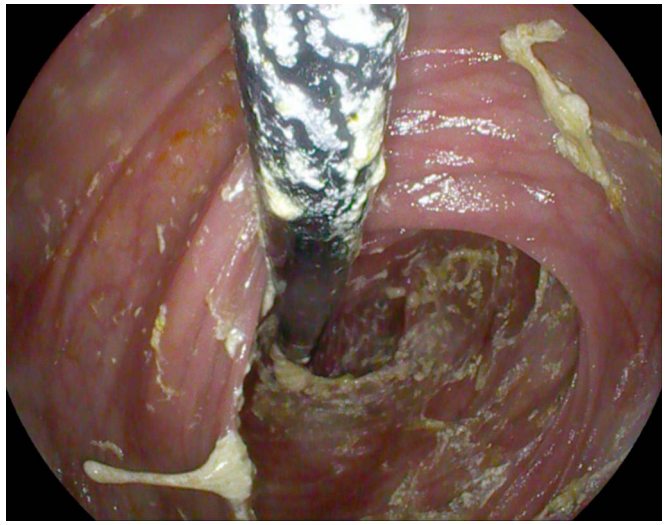

**Figure 2.** Endoscopic view of the colonic interposition reveals retained food debris and no evidence of stricture or obstruction.

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Gastric tissue is the ideal first choice for a conduit in patients requiring esophagectomy.[1,2] Colonic interpositions are used only when a gastric pull-up is not feasible in patients requiring esophagectomy because of their complexity and perioperative morbidity.[1] Complications of colonic interpositions beyond the acute postoperative period include mechanical complications such as stricture formation, polyp or adenocarcinoma in the grafted colon, reflux, aspiration pneumonia, recurrent laryngeal nerve damage, and dysmotility of the interposed segment because of redundancy.[1,2] Dysphagia because of mechanical causes or secondary to dysmotility and redundancy is common. In 1 study examining the quality of life and complications related to colonic interpositions, 20 of 24 participants reported dysphagia.[1] Although dysphagia in this population is unique in etiology, treatment with a prokinetic agent, prucalopride, was effective and safe.

Prucalopride is a prokinetic selective serotonin type 4 (5HT-4) receptor agonist, which is approved to treat chronic idiopathic constipation.[3] A recent trial demonstrates that prucalopride is an effective prokinetic agent in idiopathic gastroparesis.[4] Another study is currently underway in dysphagia and ineffective esophageal motility (Trial ID: NCT03244553). Our case demonstrates the versatility of prucalopride in an unusual case of dysphagia in a colonic conduit.

## DISCLOSURES

Author contributions: E. Helson wrote the manuscript. C.H. Seow revised the manuscript for intellectual content. Y. Nasser revised the manuscript for intellectual content, provided the images, and is the article guarantor.

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Informed consent was obtained for this case report.

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