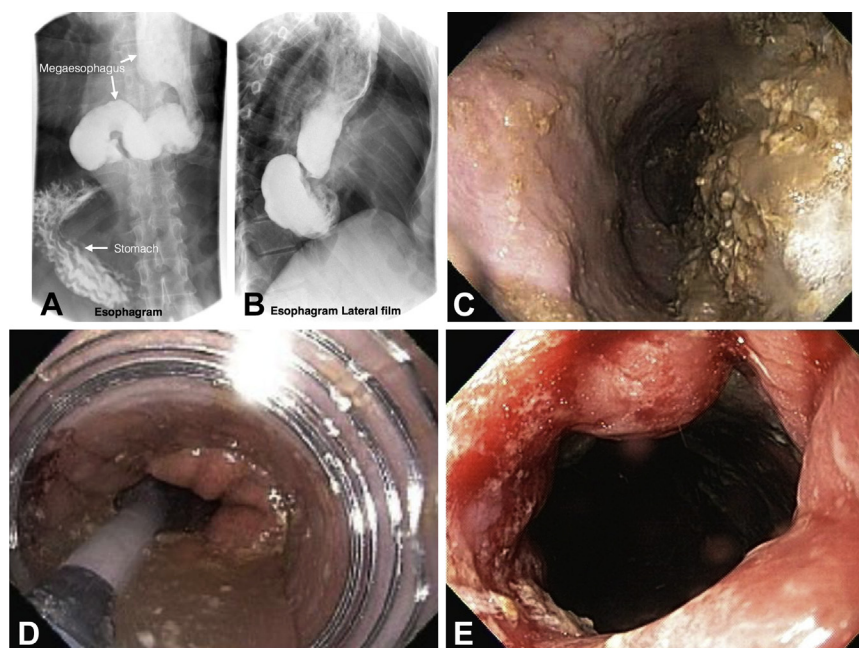


## Overtube-assisted pneumatic dilation for achalasia in megaesophagus



**Figure 1.** **A**, Frontal projection of barium esophagram showing megaesophagus/sigmoid esophagus. **B**, Lateral projection of barium esophagram. **C**, Dilated esophagus with food. **D**, Achalasia pneumatic balloon catheter inside overtube. **E**, Gastroesophageal junction post dilation.

We present an overtube-assisted technique for pneumatic dilation for achalasia in challenging cases in patients who have developed megaesophagus. A 63-year-old man with a long-standing history of achalasia presented for evaluation of dysphagia and regurgitation of food. Achalasia was initially diagnosed with an upper GI series more than 20 years previously and was subsequently confirmed by esophageal manometry 8 years before presentation. The patient had undergone at least 4 pneumatic dilations with good response over 2 decades, had been relatively asymptomatic between dilations, and had refused surgical intervention in the past. He had also modified his diet over the years to only semisolid and pureed foods.

We decided to proceed with upper endoscopy for repeated pneumatic dilation (Video 1, available online at [www.VideoGIE.org](http://www.VideoGIE.org)). Several technical problems were associated with pneumatic balloon dilation in this case, which had resulted in failure of an earlier attempt.

Written transcript of the video audio is available online at [www.VideoGIE.org](http://www.VideoGIE.org).

Because of a tortuous megaesophagus with sharp, nearly 90° angulations (Figs. 1A and B), there was significant looping of the gastroscope in the esophagus and difficulty advancing the pneumatic balloon catheter over the guidewire. Furthermore, the patient had copious amounts of retained food because of the development of the megaesophagus (Fig. 1C). We used general anesthesia with endotracheal intubation after a 2-day preparation of a clear-liquid diet before upper endoscopy.

A 50-cm-long gastric overtube with an outer diameter of 19.5 mm was introduced into the stomach, and the position of the gastroesophageal junction (GEJ) was marked externally on fluoroscopy with the use of a metal paper clip. After guidewire advancement into the stomach, the pneumatic balloon catheter was introduced through the overtube, which allowed for a straighter passage into the stomach (Fig. 1D). The overtube was then withdrawn proximally to the balloon, and pneumatic dilation was performed (Fig. 1E).

The use of a long overtube allows relatively straight passage of a balloon catheter even through a tortuous

esophagus, and it allows maintenance of the position at the GEJ for pneumatic dilation in previously failed cases. This technique requires no special devices and can be done in most endoscopy centers with standard equipment.

#### **DISCLOSURE**

*All authors disclosed no financial relationships relevant to this publication.*

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