Management

Management

In stable patients with a clear history and contained perfo ration, sometimes conservative expectant treatment can be successful. This usually applies to cervical/pharyngeal perfo ration when patients are much less septic. Antibiotics should be given; patients are kept nil by mouth and should wait for the perf oration to heal by itself. In intrathoracic perforations, patients are usually sicker. T hey should be resuscitated with intravenous fluid and given antibiotics and oxygen supplement. Electrolyte disturbances are corrected if present. Septic shock - is treated appropriately . The objectives of treatment are (i) seal the perforation if possible, (ii) adequate drainage, and (iii) supportive measures, including nutrition (alimentary preferred over par enteral), cardiorespiratory support and sepsis control. In patients with significant pleural fluid and pneumothorax that result in respiratory compromise, a wide-bore chest tube - is inserted to the appropriate side for drainage while waiting for more definitiv e investigations such as a CT scan. Endos - - copy can be both diagnostic and therapeutic. The location and size of the perforation site should be ascertained. Foreign bodies are retrieved. Endoscopic sealing of the perforation site with clips and self-e xpanding metallic stents may be possible (Figure 66.33). The stent is usually removed around 4–6 weeks later. Healing is expected to have occurred. A nasogastric tube can be placed at the same time for nutritional support. Surgical intervention is indicated in the presence of sig - nificant sepsis when drainage is not a ff ected by other means (such as interventional radiology), and no e ff ective closure of the perforation can be done otherwise. These conditions are usually present when the perforation is large, when the per - foration is in the intrathoracic oesophagus, when the pleura - is breached, when there is a large septic load and when the presentation is delayed. - When the diagnosis is delayed, closure of the perforation is unlikely to succeed; con version of the perforation into a controlled fistula is another option. A simple way would be to place a T-tube through the defect and repair around it, in addi - tion to adjacent drains. With moder n supportive treatment, oesophageal diversion (cervical oesophagostomy; often an end

(b) Figure 66.32 Epiphrenic diverticulum on a barium contrast study (a) . Endoscopic picture (b) showing the diverticulum (green arrows) and true lumen (red arrow).

stoma is required for e ff ective diversion and OGJ ligation) with later staged reconstruction is rarely needed. Oesophagec tomy is even more uncommonly indicated, perhaps except for extensive caustic burn with perforation when the oesophagus is necrotic. Summary box 66.6 Oesophageal perforation /uni25CF /uni25CF /uni25CF /uni25CF

(b) Figure 66.33 oesophagus; A potentially lethal condition due to sepsis Surgical emphysema, chest pain and vomiting constitute the classic triad of Boerhaave’s syndrome Treatment aims at adequate drainage, closure of the perforation site if possible and supportive measures Delayed diagnosis and management lead to high morbidity and mortality rates

Revision #1
Created 2025-12-31 15:24:30 UTC by Omar Ayman
Updated 2025-12-31 15:24:30 UTC by Omar Ayman