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World Organization for Specialized Studies on Diseases of the Esophagus

OESO Newsletter – December 2026

Message to the members of OESO,
and to all those who have interest in Esophagology



The **OESO-SEMPIRE**

VIRTUAL EDUCATIONAL CHANNEL
46th online meeting

From the Pilot Center of Geneva

Upper Gastrointestinal Surgery, Division of Visceral Surgery
Geneva University Hospitals, Switzerland

Hosted and moderated by
Prof. Stefan P. Mönig
Head of Upper Gastrointestinal Surgery

Thursday, 10 December 2026

- Geneva: Europe CET: 4 – 5 pm | Online meeting

Caustic oesophageal stricture and anastomotic leakage after Ivor Lewis oesophagectomy

Programme	Faculty
Introduction – 5 min	Prof. Stefan P. Mönig (Geneva)
Anastomotic technique and case discussion – 20 min	Dr Mickael Chevallay (Geneva) Dr Bruno Matos Santos (Geneva)
Robotic oesophagectomy – 10 min	Prof. Christian Gutschow (Zurich)

Multidisciplinary discussion – 25 min	Discussion panel

Time Zones: When to Connect

- **Europe CET:**
  Paris: 4 – 5 pm / UK: 3 – 4 pm
- **North America:**
  West Coast: 7 – 8 am
  East Coast: 10 – 11 am
- **South America:**
  São Paulo: 12 noon – 1 pm
  Buenos Aires: 12 noon – 1 pm
  Santiago Chile: 12 noon – 1 pm
- **Africa:**
  Bomet, Kenya: 6 – 7 pm
- **Asia:**
  Beijing: 11 pm – midnight
  Kuala Lumpur: 11 pm – midnight
- **Australia:**
  Melbourne: 2 – 3 am (Dec 11)

- Zoom technology applied

Registration is free, but mandatory:

Free registration

*



Caustic oesophageal stricture and anastomotic leakage after Ivor Lewis oesophagectomy

Moderator:

- Prof. Stefan P. Mönig (Geneva)

Presenters of the case:

- Dr Mickael Chevallay (Geneva)
- Dr Bruno Matos Santos (Geneva)

A 50-year-old woman received conservative care and jejunal feeding for severe oesophagogastric injury after alkaline ingestion. She developed a long, near-occlusive stricture unsuitable for dilatation. Laparoscopy confirmed that the stomach could serve as a conduit. She underwent open Ivor Lewis oesophagectomy on 26 May 2026. An anastomotic leak on postoperative day (POD) 3 required endoscopic vacuum therapy (EVT), pleural drainage and antimicrobials. The sponge was removed on POD 49. Contrast swallow confirmed closure on POD 63. Anastomotic and prepyloric strictures required serial balloon dilatation through November.

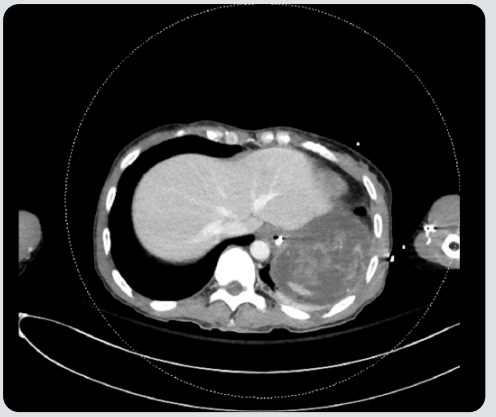
Clinical presentation and past medical history

- On 23 November 2025, a 50-year-old woman intentionally ingested approximately 300 mL of alkaline drain cleaner. Stridor, dysphonia and laryngeal oedema prompted intubation.

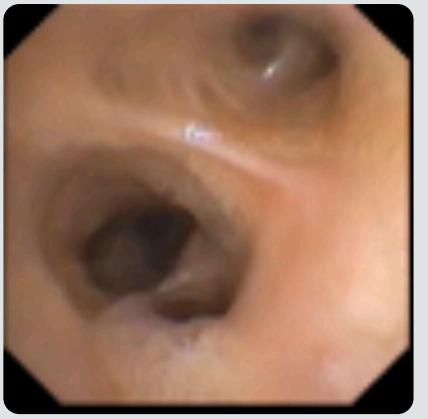
- Her history included severe depression, seronegative polyarthritis treated with golimumab, weekly methotrexate and low-dose corticosteroids, chronic urticaria, lumbar fusion and superficial venous

thrombosis.

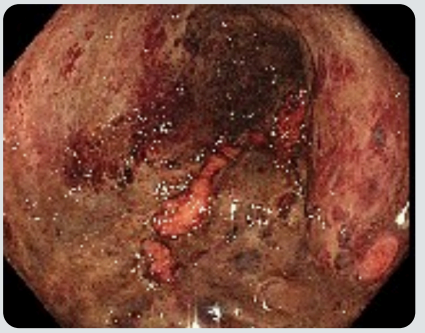
Initial assessment – 24 November 2025
CT showed oesophagogastric oedema and gastric mucosal hypoperfusion without free perforation. Gastroscopy showed Zargar grade 3A–B caustic oesophagitis and gastritis with a normal duodenum. Bronchoscopy excluded bronchial burns. The multidisciplinary team continued conservative management.



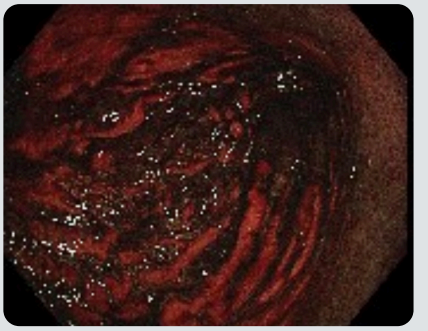
A. CT at admission



B. Bronchoscopic view



C. Gastroscopy, 24 Nov 2025



D. Gastroscopy, 24 Nov 2025

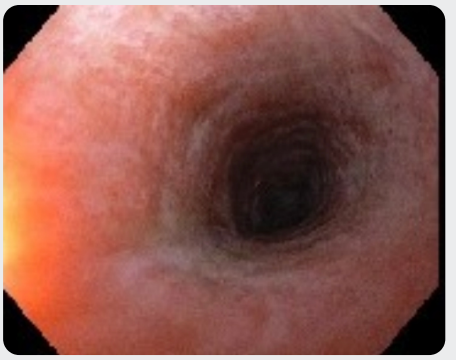
A. Admission CT. B. Bronchoscopy. C–D. Severe caustic mucosal injury on gastroscopy.

Course of treatment and reassessment

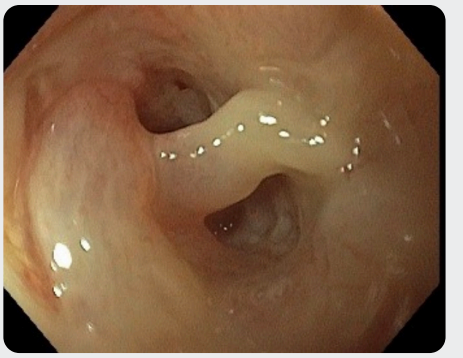
27 November–4 December 2025 – Repeat CT showed improved mucosal enhancement. Treatment included acid suppression, nutritional support and five days of piperacillin–tazobactam. She was extubated on 4 December.

8–10 December 2025 – Gastroscopy showed revascularisation, persistent friability and a stricture at 25 cm traversable only with an ultrathin scope. On 10 December, a laparoscopically assisted Witzel feeding jejunostomy was placed 30 cm distal to the ligament of Treitz.

13 January–11 February 2026 – A contrast swallow on 13 January showed a long, near-occlusive stricture. She returned home the next day on jejunal feeding. On 11 February, gastroscopy showed a 21-cm stricture with a 2-mm minimum lumen. Even an ultrathin scope could not pass. Given the anatomy, neither dilatation nor stenting was attempted.



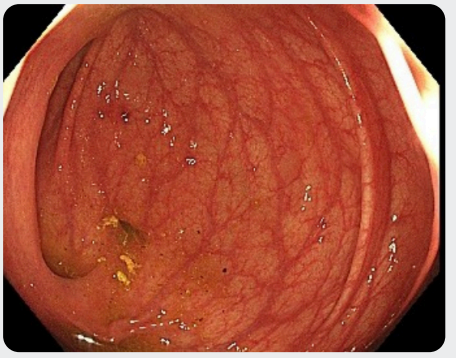
E. 8 Dec 2025
Healing with oesophageal narrowing



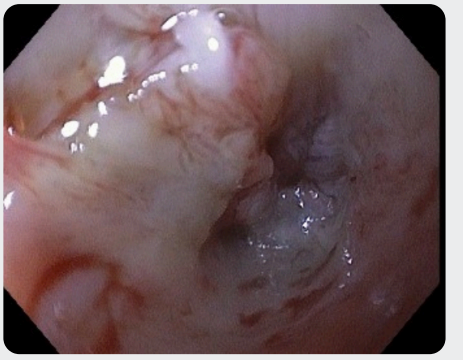
F. 11 Feb 2026
Non-traversable caustic stricture

Surgical assessment and choice of conduit

11–25 March 2026 – Preoperative colonoscopy was normal (Boston score 7/9). On 25 March, laparoscopy confirmed a supple stomach suitable for reconstruction. Gastroscopy identified a traversable stricture at 21 cm and an impassable one at 25 cm. She went home on 27 March.



G. 11 Mar 2026
Preoperative colonoscopy

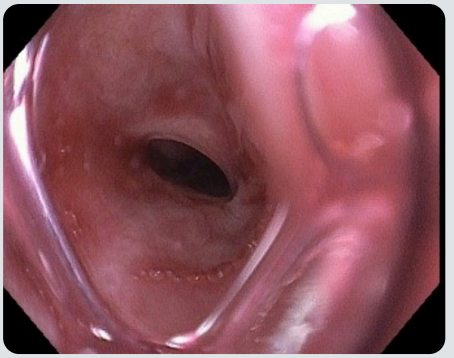


H. 25 Mar 2026
Intraoperative oesophageal assessment

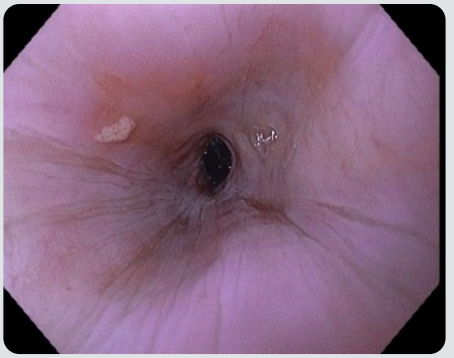
Surgery – 26 May 2026

Open subtotal Ivor Lewis oesophagectomy with a gastric conduit routed through the posterior mediastinum.

- Abdominal phase. Through a midline laparotomy, the stomach was mobilised, preserving the right gastroepiploic pedicle and an accessory hepatic branch. A Kocher manoeuvre increased conduit reach.
- Thoracic phase. Right thoracotomy through the fourth intercostal space allowed dissection of dense adhesions around the azygos vein and airways. The azygos vein was divided. Two intraoperative endoscopies guided the resection level.
- A 25-mm circular stapler was used for the intrathoracic oesophagogastric anastomosis above the azygos arch. Both tissue rings were complete. After reinforcement, the blue-dye test was negative. A right chest drain was placed and the jejunostomy secured.



I. 26 May 2026
Endoscopic localisation, abdominal phase

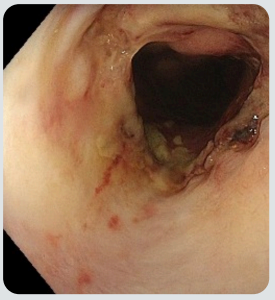


J. 26 May 2026
Endoscopic localisation, thoracic phase

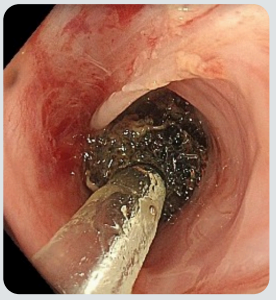
Pathology showed approximately 13 cm of benign ulceration extending to the outer muscular layer, with chronic fibro-inflammatory change. Margins and anastomotic rings were clear. All four nodes were benign.

Early postoperative complications

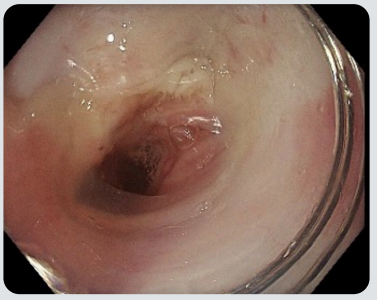
POD 3 – Cardiorespiratory deterioration prompted a contrast swallow, which suggested a leak. Gastroscopy confirmed a small defect in a patent anastomosis at 20 cm. An intraluminal Eso-SPONGE was placed, with a proximal mucosal tear caused by the overtube. Piperacillin–tazobactam was started and jejunal feeding continued.



K. 29 May 2026
Anastomotic assessment



L. 29 May 2026
First intraluminal vacuum sponge



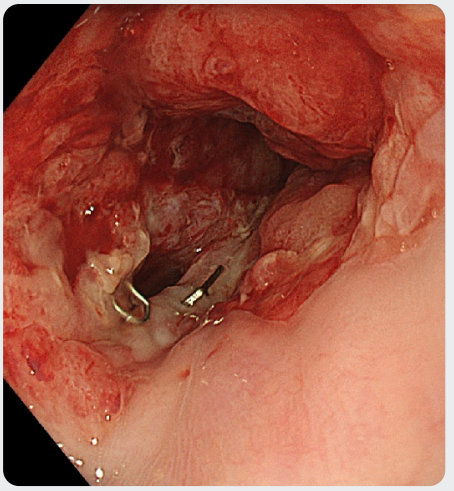
M. 2 Jun 2026
Assessment at first sponge exchange

POD 7 – At the first sponge exchange, the margins were ulcerated and fibrin-covered, with no visible defect. EVT continued. Caspofungin was added on POD 8.

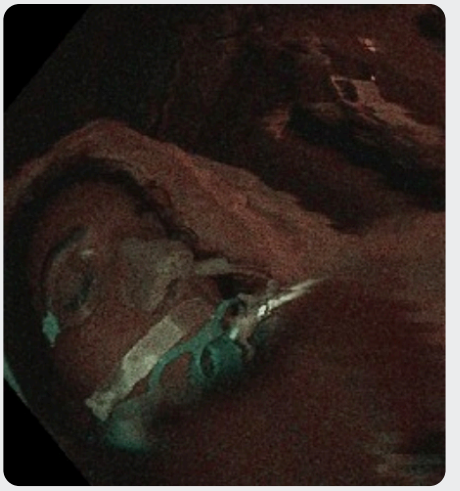
Persistent leakage and serial endoscopic treatment

POD 9–10 – CT showed persistent leakage with a 20 x 22 x 74 mm mediastinal air–fluid collection. On POD 10, endoscopy showed sponge migration into the pharynx and a 5-mm posterior defect. Treatment included lavage, intraluminal sponge replacement, pyloric dilatation to 15 mm and drainage of a left pleural effusion (20 Fr).

POD 15–23 – The left drain was removed on POD 15. On POD 16, the 5-mm defect persisted. A fourth sponge was placed and the pylorus again dilated to 15 mm. Exchanges on POD 20 and 23 showed a 5-mm posterior defect without pus. The right drain was removed on POD 21.

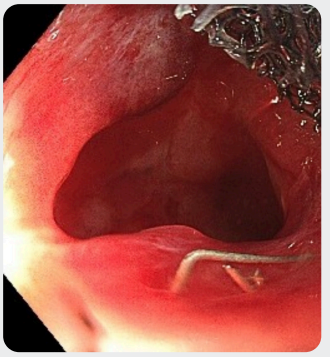


N. 11 Jun 2026
Persistent anastomotic defect

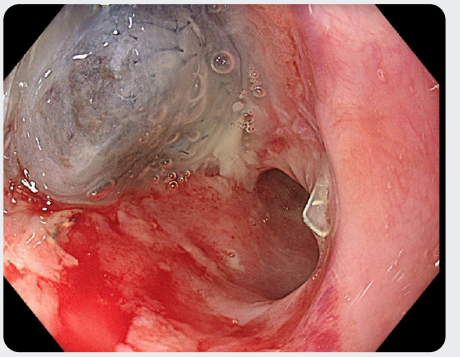


O. 18 Jun 2026
Continued vacuum treatment

POD 27–43 – On POD 27, the posterior defect opened into a mediastinal cavity. Its margins were treated with argon plasma coagulation and the sponge replaced. CT the next day showed a smaller collection. The sponge was exchanged on POD 31 and 36. On POD 36 the defect measured 5 mm, without pus. By POD 43, contrast outlined a blind-ending tract through a 3-mm opening. The sponge was replaced and the pylorus dilated to 8 mm.



P. 22 Jun 2026
Posterior opening into the cavity

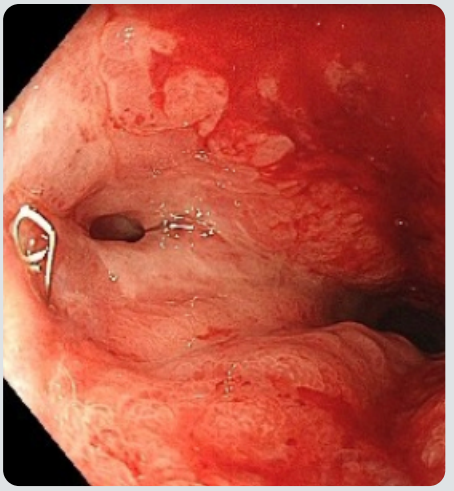


Q. 1 Jul 2026
Assessment during sponge exchange

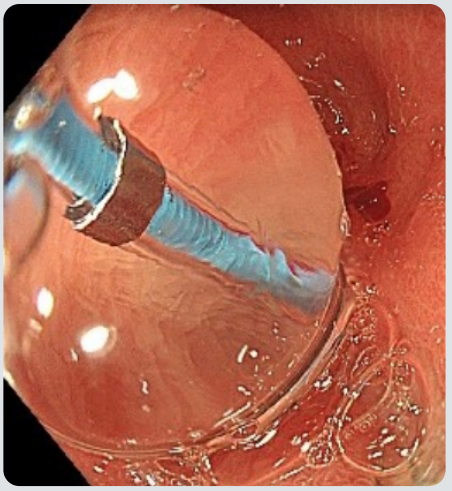
EVT, drainage, jejunal feeding and antimicrobials continued. Methotrexate and golimumab were withheld during infection. Corticosteroids continued.

Resolution of the leak and recovery of oral intake

POD 49 – At final sponge removal, contrast outlined a 3-cm blind-ending tract through a residual 3-mm opening. Pylorus was dilated to 10 mm.

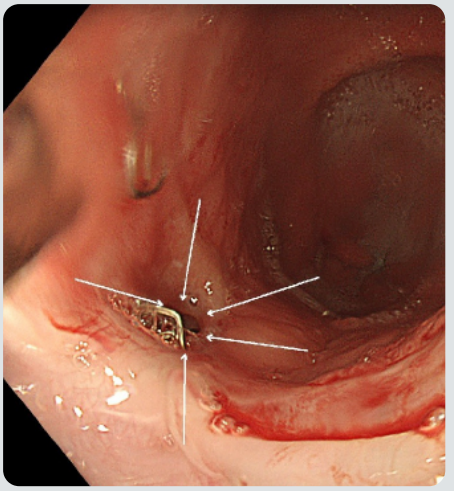


R. 14 Jul 2026
Residual opening at sponge removal

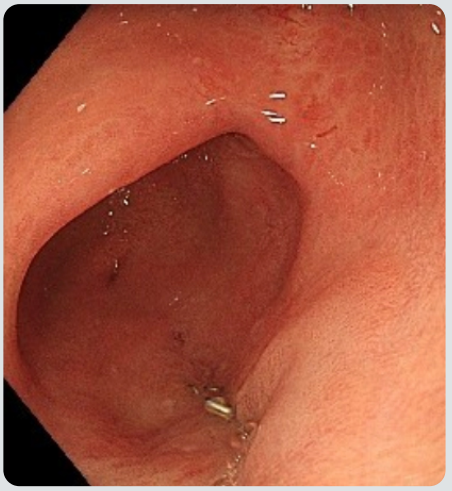


S. 14 Jul 2026
Associated pyloric dilatation

POD 56–58 – CT for recurrent fever showed a small residual air-containing outpouching without active leakage and uncomplicated rectopancolitis. On POD 58, gastroscopy showed a patent anastomosis with a residual 2-mm opening and no signs of infection. Stomach was empty and the narrowed pylorus traversable.



T. 23 Jul 2026
Favourable anastomotic healing



U. 23 Jul 2026
Traversable distal narrowing

POD 63–66 – Contrast swallow on POD 63 showed no leak or anastomotic stenosis. After swallowing assessment, she advanced to a pur.ed diet and went home on POD 66 with supplementary jejunal feeding.

Antimicrobial treatment during the postoperative course

Dates in 2026	Treatment
29 May–25 June	Piperacillin–tazobactam
3 June–3 July	Caspofungin
25 June–3 July	Imipenem
3–10 July	Ceftriaxone + metronidazole + fluconazole
10 July	Continuous therapy stopped. Periprocedural prophylaxis proposed.

From 21 July, 7 days	Ceftriaxone + metronidazole for rectopancolitis

On POD 45, clinical improvement and leak control supported the infectious diseases team's decision to stop continuous therapy.

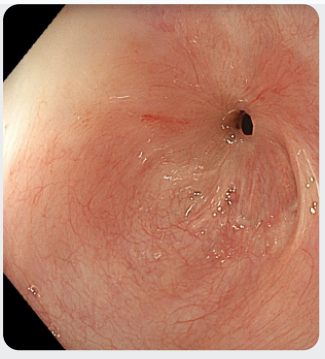
Late follow-up and treatment of benign strictures

4 August 2026 – She tolerated liquids and purées but still had solid-food dysphagia and needed nocturnal jejunal feeding.

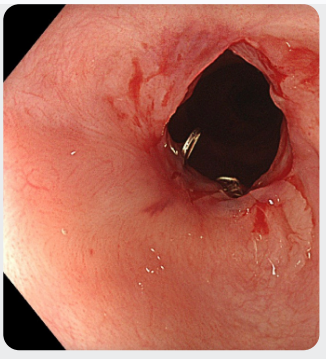
1–9 September 2026 – Progressive dysphagia prompted readmission. CT showed a 3-mm anastomotic lumen without extravasation. Contrast swallow on 3 September confirmed stenosis without leakage. Serial balloon dilatation began.

Endoscopy	Anastomotic / distal dilatation	Result
8 September	10 mm / not examined	Adult scope could not pass
24 September	12 mm / not examined	Adult passage remained difficult
8 October	13.5 mm / pyloric 10 mm	Anastomosis traversed; distal narrowing not traversed
27 October	15 mm / prepyloric 12 mm*	Passage beyond distal narrowing
10 November	15 mm / prepyloric 13.5 mm*	Progression to the second duodenum

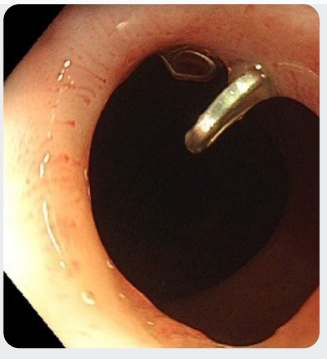
* Maximum diameters are from the treatment summaries and conclusions. The procedure narratives report lower values.



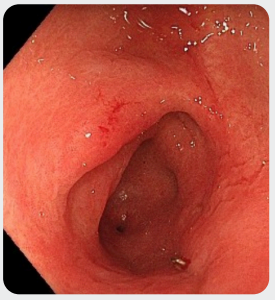
V. 8 Sep 2026
Anastomotic stricture



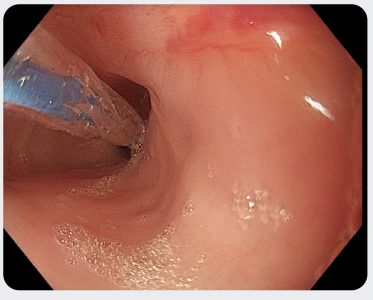
W. 24 Sep 2026
After balloon dilatation



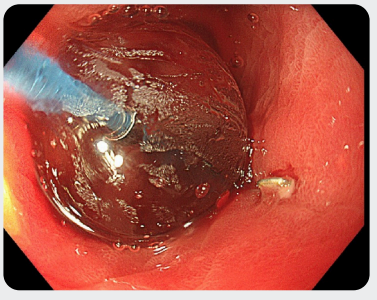
X. 8 Oct 2026
Anastomotic dilatation



Y. 27 Oct 2026
Prepyloric narrowing



Z. 10 Nov 2026
Anastomotic dilatation



AA. 10 Nov 2026
Prepyloric dilatation

By 10 November 2026, leak had healed. Both benign strictures still required treatment, with repeat dilatation planned two weeks later.

Topics for discussion:

1. **Initial management and timing of reconstruction**
   Which clinical, CT and endoscopic findings favour conservative management? When does a long, impassable stricture warrant reconstruction, and how should nutritional and psychiatric recovery influence timing?
2. **Selection of the conduit and operative approach**
   How can gastric viability be assessed after oesophagogastric injury? When does staged laparoscopy help, and when is colonic interposition preferable? How do fibrosis and a high stricture affect the approach?
3. **Anastomotic technique and prevention of leakage**
   How should anastomotic height, tissue quality, diameter, tension and conduit perfusion guide technique? What additional precautions are appropriate in malnutrition and immunosuppression?
4. **Treatment of a small leak with a mediastinal collection**
   When should a small leak be treated with intraluminal or intracavitary EVT, a covered stent, endoscopic closure or surgery? How should persistent leakage, sponge migration or pleural collections guide reassessment and drainage?
5. **Treatment duration and functional recovery**
   What guides sponge-exchange intervals and the duration of EVT and antimicrobials? How should a residual blind-ending tract be assessed before oral feeding? How should recurrent anastomotic and prepyloric strictures be managed and monitored?

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*Thirty-seven Pilot Centers worldwide are currently listed in the network of the OESO-SEMPIRE Platform of Excellence in Esophagology to take part in the program of the **OESO Virtual Educational Channel in Esophagology.***

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*Such a program is in line with true multi-disciplinarity, the essence of OESO since its creation, and the mission defined by UNESCO in the **Chair of Digital Education** attributed in 2018, to the OESO Foundation at the University of Geneva.*

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The previous "Staff meeting discussions" were organized in

- **2020:** May 28 (Pilot Center of Milan), July 22 (Pilot Center of Stanford), October 3 (Pilot Center of Bomet, Kenya), October 29 (Pilot Center of Beijing), December 10 (Pilot Center of Geneva),
- **2021:** January 29 (Pilot Center of Melbourne), February 25 (Pilot Center of Bordeaux), March 19 (Pilot Center of Stanford), April 15 (Pilot Center of Paris), May 26 (Pilot Center of Milan), June 23 (Pilot Center of Sao Paulo), August 21 (Asian Pacific Digestive Week), October 19 (Pilot Center of Mainz), November 22 (Pilot Center of Bordeaux), December 9 (Pilot Center of Geneva),

- **2022:** January 20 (Pilot Center of Kota Bharu), February 22 (Pilot Centers of Beijing, Shanghai and Guangzhou), March 24 (Pilot Center of Boston), May 4 (Pilot Centers of Melbourne and Kenya), July 19 (Pilot Center of Kota Bharu), September 23 (Pilot Center of Milwaukee, Wisconsin), October 8 (Pilot Center of Chile), December 14 (Pilot Center of Geneva),

- **2023:** January 11 (Pilot Center of Stanford), February 26 (Pilot Center of Malaysia), March 23 (Pilot Center of Boston), May 24 (Pilot Center of Paris), June 1 (Pilot Center of Chile), September 28 (Pilot Center of Milwaukee, WI), November 30 (Pilot Center of Geneva and London), December 18 (Pilot Center of Zurich),

- **2024:** January 24 (Pilot Center of Houston, Texas), February 20 (Pilot Center of Verona), June 5 (Pilot Center of Guangzhou), July 18 (Pilot Center of Bomet), October 9 (Pilot Center of Hong Kong), November 27 (Pilot Center of Houston, Texas),

- **2025:** January 22 (Pilot Center of Beijing), March 5 (Pilot Center of Geneva), May 8 (Pilot Center of San Paulo), October 2 (Pilot Center of Belgrade), November 12 (Pilot Center of Amsterdam),

- **2026:** January 24 (Pilot Center of Beijing), March 17 (Pilot Center of Vienna) and April 28 (Pilot Center of São Paulo).

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- ***Wherever you are in the world,***
- ***Whatever your specialty,***
- ***Whatever your level,***

the 46th clinical case of the OESO-SEMPIRE Platform will afford you the opportunity to participate in a global staff meeting dedicated to one challenging topic of esophagology.
Participants from any country can connect to the discussion.

Looking forward to seeing you soon!

Robert Giuli, MD, FACS
Professor of Surgery
Founder & Deputy Executive Director of OESO

The next 47th clinical case coming up for discussion will be announced in the next Newsletter and on the website.

The OESO-SEMPIRE 18th World Congress 2028



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