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Commentary

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The 'cross' of Oesophageal Stricture in Childern

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One of the devastating clinical entities in children, especially in the developing world is oesophageal stricture. Majority of these cases are acquired from accidental ingestion of caustic soda. In this edition, the HIS Journal has shown that over 70% of children who presented with oesophaeal stricture for oesophageal dilation were from caustic soda ingestion. There are articles that have shown increasing incidence in Africa [1]. Other causes of oesophageal stricture in children even though uncommon are congenital and other acquired causes namely post-operative oesophageal procedures, trauma from impacted foreign body, eosinophilic oesophagitis, reflux oesophageal stricture and after radiation radiation therapy. The aetiology varies between countries [2]. Majority of these children diagnosed with caustic oesophageal stricture are under five years. The circumstances leading to accidental ingestion have always been that this toxic substance often used for local soap making is kept in familiar containers. The unsuspecting children are attracted to these containers and mistakenly ingest the content as water [1]. The immediate complication of this ingestion may lead to burns in the gastrointestinal and the respiratory systems leading to death in some cases. The long-term complications may render these children nutritionally incompetent unless an alternative source of feeding is constituted. In this edition, the HSI Journal has shown successful management of children with oesophageal stricture by dilation. This procedure, especially in children with oesophageal stricture is already known and a welcome procedure for dilatable lesions. Expertise, equipment and the cost of management of these children in a developing world could be a limiting factor. This management procedure however is less of the cost when a major surgery to replace the oesophagus is needed.

The mechanism involved in the dilation of oesophageal strictures is splitting of the stricture and mechanical stretching. These are usually performed to prevent stiffness of the scar when remodelling occurs [3].

Currently there are three types of oesophageal dilators in practice: wire guided Savary-Gilliard dilators, weighted Maloney dilators, and endoscopic balloon dilators (EBD). EBD is increasingly recognized as a better choice [2,4]. In this edition, Savary-Gilliard dilators were used with an impressive success rate. In the absence of fluoroscopy to help with the guide wire placement, gastroscopy through a feeding gastrostomy was used. This is a demonstration of maximizing available equipment to achieve the best.

The use of conscious sedation was a very efficient way of reducing the cost of general anaesthesia and safely accomplishing the desired objective. Many reports have suggested that all endoscopic interventions should be performed under general anaesthesia in paediatric patients [5] but the study in this edition has demonstrated a seamless conscious sedation procedure and an effective and successful endoscopic dilation with minimal complications. The frequency of endoscopic dilation is a great concern. This eventually increases the cost of treatment and exposure to possible complications. It is important to investigate the predictors of multiple dilations of oesophageal strictures

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in children. This will serve as a guide in counselling mothers of these children and the need to explore other options of treatment. The use of covered self-expandable stents has improved the management of oesophageal strictures in the developed world. These are removable and the use of these stents has expanded in cases of refractory stenosis [3].

The mother question that should concern all involved in the use of endoscopic dilation of caustic oesophageal stricture is the development of carcinoma in the injured oesophagus after treatment. How safe is the long-term outcome after this procedure? A high risk of future development of oesophageal cancer will defeat this mode of treatment.

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