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Advice for patients and carers about having an

Oesophageal Stricture

Endoscopy Department Patient information

What is an oesophageal stricture?

The oesophagus (also called the gullet) is the tube through which food and drink passes on its way from the mouth to the stomach. Normally, the muscles lining the oesophagus contract (peristalsis), to assist the passage of food and fluid. The lower oesophageal sphincter (a ring of muscle) at the bottom of the oesophagus, opens to allow food and fluid to pass through and closes to prevent the stomach contents coming back up (reflux).

An oesophageal stricture is a narrowing which forms in the lining of the oesophagus. Strictures may be described as benign (non-cancerous) or malignant (cancerous), depending on the cause.

What are the symptoms of oesophageal stricture?

In some cases, an oesophageal stricture may not cause any symptoms at all, and may be detected in the course of other investigations. Symptoms may develop gradually over time, and usually involve dysphagia (difficulty swallowing). It may feel painful at times, or as though something is stuck in your oesophagus. Food may be vomited or regurgitated (brought up). In very rare cases, food may become lodged above the stricture, leading to a need to seek urgent treatment to remove the blockage (which can be performed at endoscopy). Weight loss may also be a common feature, and can be severe and lead to malnutrition. It is very important to seek prompt advice if you develop any of these symptoms, in order that the cause can be identified.

What causes oesophageal strictures?

GORD: Oesophageal strictures are most commonly caused by scarring from the reflux of acid, which is produced by the stomach to help break down food. This is called gastro-oesophageal reflux disease (GORD). Over time, the repeated inflammation and / or ulceration caused by the reflux of acid can lead to the development of scar tissue, which may result in narrowing and lead to symptoms such as dysphagia.

Webs: These are smooth extensions of the oesophageal lining tissue (mucosa), which can occur anywhere in the length of the oesophagus, but tend to be located in the higher portion. They are more common in women than men, and may be related to iron deficiency (anaemia).

Rings: These are made up of mucosa and muscle, and are concentric in shape. Rings are classified into three types. Types A and C rarely cause any symptoms and may be found incidentally in the course of investigations such as endoscopy or X-ray. Type B (also called Schiatzki's ring) is technically a form of web as it does not involve muscle tissue. Schiatzki's rings tend to occur at the base of the oesophagus, in the presence of a hiatus hernia. They are more common in male patients over 50 years of age, and may produce symptoms such as dysphagia.

Malignancy: Strictures may also result from cancerous (malignant) growths in or around the oesophagus. Further investigations such as CT scan or endoscopic ultrasound are required in order to establish the extent of the problem, and plan what treatment may be necessary.

Less common causes include scarring from radiation therapy, anastomotic strictures (at the site of a surgical operation), caustic injury (from swallowing corrosive substances), prescribed medications (e.g. alendronate or non-steroidal anti-inflammatories) and complications of conditions of the oesophagus such as achalasia, eosinophilic oesophagitis and oesophageal varices.

Separate advice sheets are available in the Endoscopy Department about GORD, achalasia and oesophageal varices. Please ask a member of the nursing team for more information.

How is oesophageal stricture diagnosed?

Your GP can refer you for investigations as an outpatient at the hospital. These may include:

Barium swallow: This involves drinking a liquid which shows up very clearly on x-ray, highlighting whether the oesophagus is narrowed, and helping to measure the length of the narrowing. A simple chest x-ray may show a stricture or abnormality in the oesophagus.

Gastroscopy: A thin, flexible tube with a camera on the end is passed down the throat into the oesophagus and stomach. This can be performed with local anaesthetic throat spray, and / or a light sedation if necessary. The endoscopist can check the lining of the oesophagus, the lower oesophageal sphincter (or valve) and the stomach, to rule out other disorders. Biopsies (tissue samples) may also be taken and sent for analysis to help with the diagnosis.

How are oesophageal strictures treated?

The main aim of treatment is to enable food and drink to be taken so that malnutrition and weight loss can be prevented or reversed and quality of life improved.

Dilatation: Benign strictures or rings are usually managed by dilatation. This involves stretching the sphincter with a balloon, which is inflated to widen the muscle at the base of the oesophagus. It is performed during an endoscopic procedure called a gastroscopy, usually under sedation as it can be a little uncomfortable. Dilatation can lead to complications, including perforation (where a tear can result) or bleeding, but these are rare. It is not unusual for patients to require repeated dilatations, and strictures can recur over time.

Medication: Proton pump inhibitors (PPIs) such as Omeprazole and Lanzoprazole may be prescribed to reduce inflammation from acid reflux. This can help to reduce the likelihood of strictures recurring in some patients. Steroids may also be helpful in reducing the inflammation associated with eosinophillic oesophagitis.

Surgery: Strictures which do not respond to dilatation, or are malignant may require surgical treatment, which may involve an operation to remove the affected part of the oesophagus.

Stenting: This involves the placement of a tube to hold the stricture open and allow food and drink to pass. Stents may be removable or permanent and tend to be used to help ease the symptoms of malignant strictures, often in conjunction with other treatments such as chemotherapy or radiotherapy. Stent placement is performed during endoscopy, sometimes with x-ray guidance.

After treatment, particularly dilatation or surgery, tips such as chewing your food well, taking plenty of fluid with your meals, sitting upright to eat, elevating the head of the bed to prevent regurgitation or reflux at night, and avoiding troublesome foods such as meat or bread can help. Cool fluids and simple analgesia (painkillers) may be soothing for those who experience chest pain after treatment. Your doctor can discuss the options with you, and refer you for specialist advice.

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