Sultanate of Oman
Ministry of Health
The Royal Hospital
Department of Surgery

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Title: Management of Oesophageal Injuries

Protocol

Management of Oesophageal Injuries

The Aim of this protocol is to clarify the clinical pathway and the department responsible for managing any oesophageal injuries including perforations.

Oesophageal injuries may be associated with chest trauma.

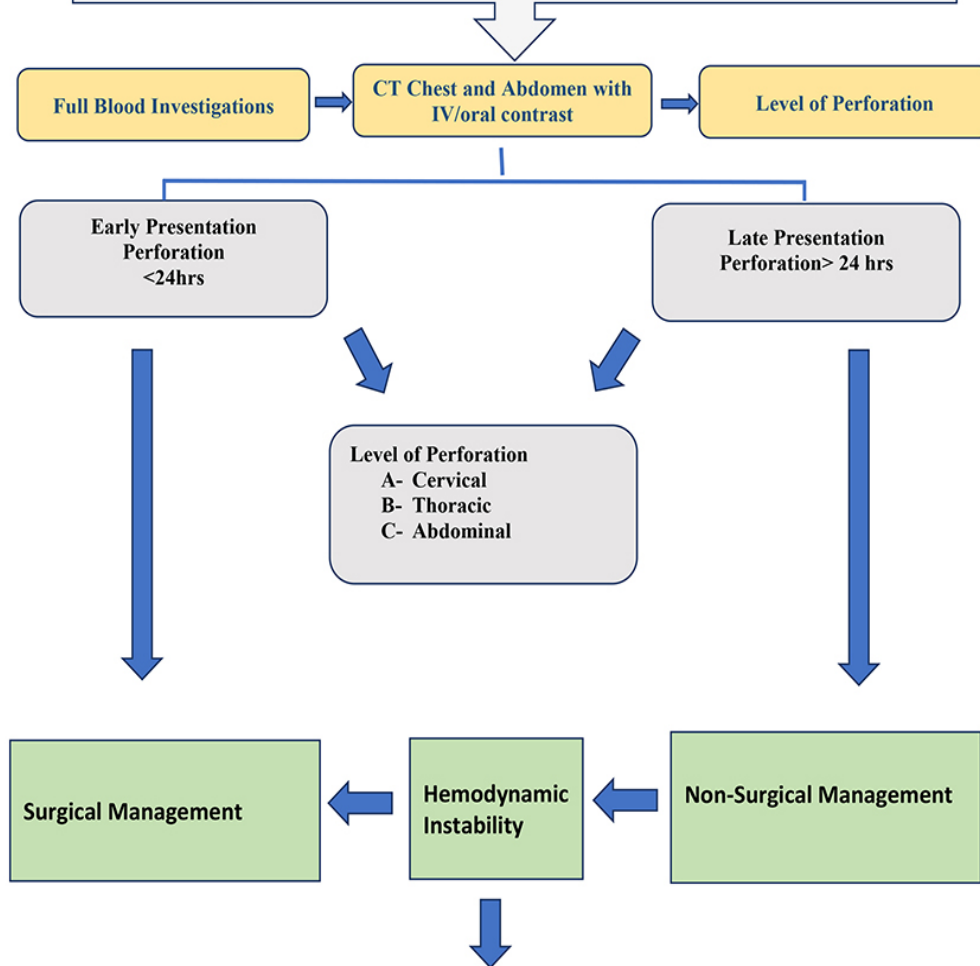
The Upper GIT surgeons are responsible for managing Oesophageal injuries, whereas the management of Cardiac and Lung injuries will be under the care and expertise of the Cardiothoracic surgeons.

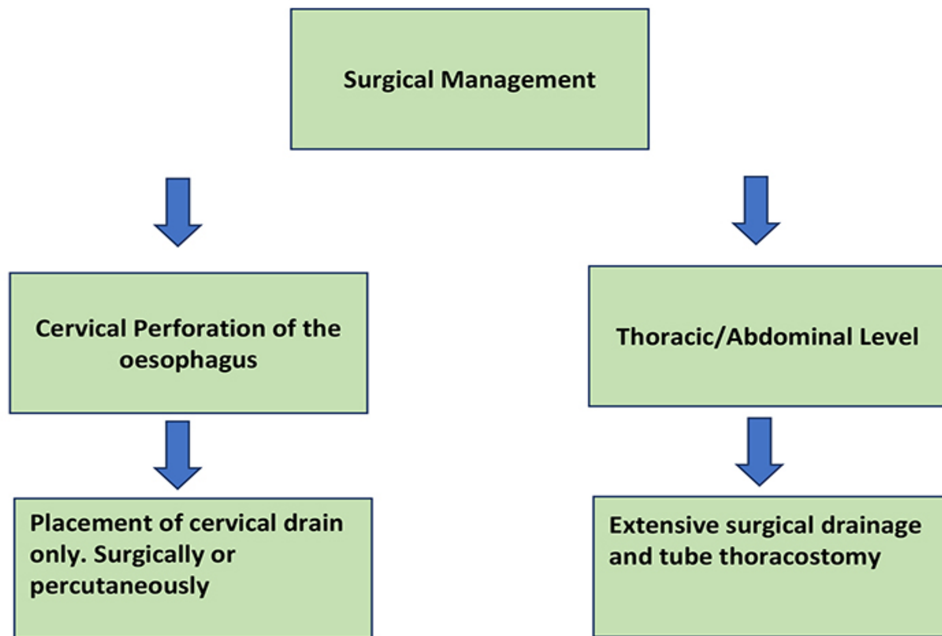
OESOPHAGEAL PERFORATION PATHWAY

Oesophageal perforation or rupture is a life-threatening condition in which the cervical, thoracic, or intra-abdominal oesophageal sections are perforated or ruptured iatrogenically, traumatically, spontaneously, or through the ingestion of foreign bodies

The Resuscitation of this critical condition should be started promptly in the resuscitation area of an emergency room with continuous care in a HD or ICU settings.

The patient should be transferred to the Upper GI Unit of the Royal Hospital as soon as possible from any of the MOH health facilities unless the specialized service is locally available.





PRINCIPLES OF SURGICAL MANAGEMENT

Debridement with primary closure
Insertion of feeding jejunostomy and draining gastrostomy for nutrition and to allow distal drainage
• Use of endoscopic treatment is increasing for perforations recognized immediately, not associated with pleural or mediastinal contamination, in clinically stable patients with no signs of sepsis. • Treat intrathoracic oesophageal perforation smaller than 6 cm with immediate placement of oesophageal endoscopic clips or stent to close the defect

Non-Operative Management for Delayed Oesophageal Perforation

Indicated for most patients with cervical oesophageal perforation and for those with the following:

* Well-contained perforation and minimal mediastinal soilage on imaging or endoscopic injury limited to the oesophageal wall

* No malignancy, stricture, or obstruction in area of perforation [8]

* No evidence of systemic infection

* Hemodynamic stability

* Late presentation (24 hours after incident), but good clinical condition [16]

* Contained cavity that drains back into oesophagus

* No perforation into abdominal cavity

* No free extravasation of contrast

Total parenteral nutrition through a central catheter or indwelling IV line

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