



Aorto-esophageal Fistula Bleeding: Emergent Hemostasis by Foley Catheter

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To the Editor

Aorto-esophageal fistula (AEF) bleeding is a rare and devastating condition of upper gastrointestinal (GI) bleeding with high mortality rate. Prompt diagnosis and immediate surgical intervention are mandated to save the patient's life. We share our experience of using Foley catheter for emergent hemostasis during endoscopic procedure.

A 60-year-old man presented to the emergency department with massive hematemesis. Upon arrival, his blood pressure was 95/44 mmHg with heart rate 104 beats/min. He complained about chest and back pain after eating fish two weeks ago. On examination, he looked ill and pale, with intermittent fresh blood hematemesis. Contrast-enhanced computed tomography (Fig. 1, arrow) showed an outpouching lesion at the aortic arch with surrounding abnormal gas collection, compatible with an AEF. Emergent esophagogastroduodenoscopy (EGD) disclosed a pulsating bulging lesion with adherent blood clot at the upper esophagus, with intermittent bleeding (Supplement Video 1). Under endoscopic guidance, a Foley catheter was inserted with biopsy forceps as a stilet, Foley balloon was inflated over the bleeding lesion for hemostasis. After successful temporary hemostasis of the bleeding, emergent thoracic aortography was performed and an endovascular stent was implanted. The patient survived through the event.

The cardinal symptoms of AEF included mid-thoracic pain, sentinel arterial upper GI hemorrhage, and exsanguination in a brief period. Contrast-enhanced

computed tomography and aortography are standard diagnostic modalities. In a previous report, Sengstaken-Blakemore tube had been used for stopping active bleeding from AEF.¹ Using Foley catheter for AEF hemostasis has never been reported before. It is easily available in the emergency facilities and can be rapidly setting up in critical time. The method can be used during endoscopic examination, as a bridge to definite management, such as endovascular intervention or emergent surgical vascular repair.²

Conflicts of Interest Statement

This research did not receive any specific grant

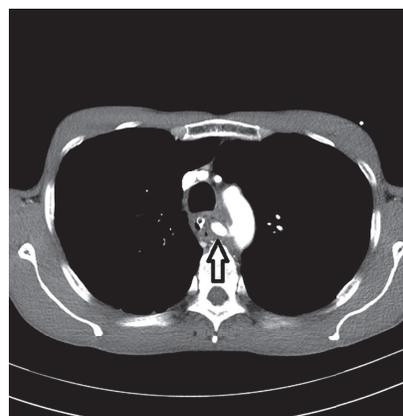


Fig. 1. Computed tomography revealed outpouching at the aortic arch (arrow) with surrounding abnormal gas collection, indicating an aorto-esophageal fistula.

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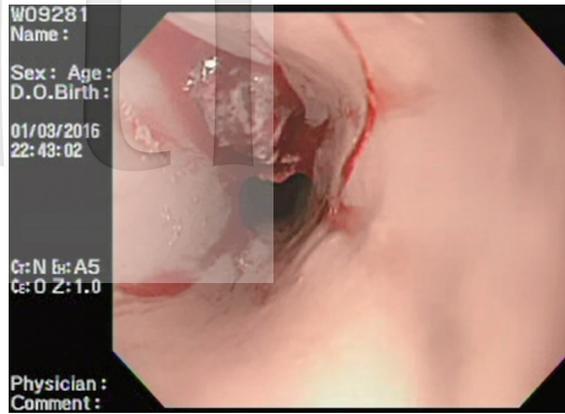
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Supplement Video 1. Emergent esophagogastroduodenoscopy disclosed a pulsating bulging lesion with adherent blood clot at the upper esophagus, with intermittent bleeding. Under endoscopic guidance, a Foley catheter was inserted with biopsy forceps as a stylet, Foley balloon was inflated over the bleeding lesion for hemostasis.

Please see Video 1 at [http://doi.org/10.6705/j.jacme.201906_9\(2\).0007](http://doi.org/10.6705/j.jacme.201906_9(2).0007)