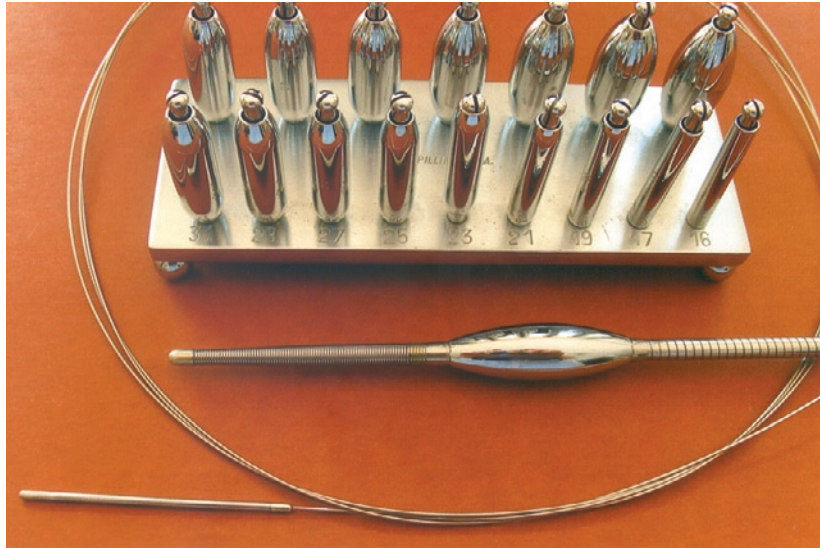


Eder-Puestow “Stringless” Dilators

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Balloon dilators were first used at this time. Physicians would place a hollow metal sound with a conical end piece and a 10-cc balloon just proximal to the end in the stricture; the balloon was then inflated to dilate the stricture. Metal sounds connected to a diathermy machine were used and were said to be “occasionally of great help and harmless.”(4)

In his classic 1946 text *Gastro-enterology* (5), Henry Bockus's preferred method of dilatation was *per oral* esophagoscopy bougienage using the Sippy technique. However, he did use string-guided retrograde bougienage following gastrostomy for complicated strictures in adults and children. In the 1963 edition (6), his preference was for round-tipped, mercury-filled bougies of the Hurst type.

Starting in 1965, I too routinely used Hurst bougies quite successfully, as they were well tolerated by patients and it was easy to gauge the degree of stricture resistance. Later, doctors began replacing Hurst bougies with tapered-tip, mercury-filled Maloney bougies, which are safer.

For complicated strictures, physicians have used sets of Savary-Gilliard thermoplastic dilators (7), over a guide wire placed in the antrum, often used in conjunction with fluoroscopy. TTS (through-the-scope) balloons that are passed with or without the assistance of a guide wire are currently used for complicated strictures.

The accompanying photograph is of a recently discovered set of Eder-Puestow dilators dating from the 1950s. It consists of a

six-foot-long guide wire with a two-inch flexible tip, a 60-cm hollow flexible spring dilator to accommodate the wire, and a set of graduated olive-shaped dilators. The guide wire was passed through a rigid Eder-Hufford esophagoscope and anchored in the stomach; then the scope was withdrawn. The flexible spring dilator with a small olive-shaped bulb just proximal to the distal end was passed over the wire and through the stricture. The endoscopist then unscrewed the spring dilator near the distal end so that progressively larger olives could be attached and passed through the stricture. This system permitted the guide wire to negotiate an area of marked stenosis where a string guide could not pass. Fluoroscopic control was not necessary.

As one can see, over the past 100 years a variety of procedures and techniques have been used for dilating esophageal strictures. Who knows what new innovations await us in the future?

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