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Distinguishing Benign and Malignant Oesophageal Strictures: A Comprehensive Review

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Abstract

Oesophageal strictures are classified as benign or malignant based on etiology, clinical presentation, and pathological characteristics. Benign strictures often result from chronic inflammatory conditions such as gastroesophageal reflux disease (GERD), caustic ingestion, radiation therapy, or post-surgical complications. They are typically managed with endoscopic dilation, stent placement, and proton pump inhibitors (PPIs). In contrast, malignant strictures, primarily caused by oesophageal carcinoma, are characterized by rapid progression, weight loss, and systemic symptoms. Diagnostic tools, such as histopathological examination, barium swallow, endoscopic ultrasound (EUS), and PET-CT scans, are essential for differentiating between benign and malignant strictures. Timely recognition of malignancy is crucial for appropriate oncologic intervention. This review explores the clinical, radiological, and histopathological features that distinguish benign from malignant oesophageal strictures, along with the corresponding diagnostic modalities and treatment strategies.

Keywords: Oesophagitis, Etiology, Epidemiology, Oesophageal Strictures, Pathophysiology

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1. Introduction

An oesophageal stricture refers to an abnormal narrowing of the oesophagus, the muscular tube responsible for transporting food and liquids from the mouth to the stomach. This narrowing can lead to dysphagia, or difficulty swallowing, which can significantly impact a patient's nutritional status and quality of life [1]. Oesophageal strictures are broadly categorized into benign (non-cancerous) and malignant (cancerous) types, each associated with distinct etiologies, clinical characteristics, and management strategies.

Benign oesophageal strictures are most commonly the result of chronic gastrooesophageal reflux disease (GERD), in which prolonged acid exposure leads to inflammation and subsequent scarring of the oesophageal lining [2]. Other causes include radiation therapy, caustic ingestion (such as ingestion of strong acids or alkalis), postoperative changes, and certain infections, particularly in immunocompromised individuals [3]. These strictures often present with progressively worsening dysphagia to solids and sometimes liquids. Malignant oesophageal strictures are primarily due to oesophageal cancer, particularly squamous cell carcinoma and adenocarcinoma [4]. These malignant strictures are typically associated with a more rapid progression of dysphagia, significant weight loss, and sometimes odynophagia (painful swallowing).

Treatment approaches differ based on the type and cause of the stricture. Benign strictures are commonly managed with endoscopic dilation, often

combined with proton pump inhibitor (PPI) therapy to reduce acid reflux and prevent recurrence [5]. In refractory cases, corticosteroid injections, oesophageal stent placement, or even surgical intervention may be necessary. Malignant strictures often require palliative treatment to relieve dysphagia, including endoscopic stenting, radiation therapy, chemotherapy, or a combination thereof [6]. Early diagnosis and tailored management are critical in improving outcomes and maintaining quality of life for patients with oesophageal strictures. This review aims to provide a comprehensive comparison between benign and malignant oesophageal strictures, with a focus on their etiology, epidemiology, clinical manifestations, diagnostic approaches, pathophysiology, and treatment strategies.

2. Common clinical symptoms of oesophageal strictures

Patients with oesophageal strictures, whether benign or malignant, commonly present with a range of symptoms that reflect the narrowing of the oesophageal lumen. Dysphagia, or difficulty swallowing, is the most frequent symptom and is often described as a sensation of food sticking in the throat or chest. It typically begins with solids and may progress to liquids as the stricture worsens [7]. Odynophagia, or painful swallowing, can also occur and may significantly impact oral intake [8]. Other symptoms include regurgitation of food from the stomach back into the mouth [9] and unintended weight loss, usually resulting from reduced food intake due to swallowing difficulties [10]. Many patients report heartburn, a burning sensation in the chest often associated with acid reflux [9]. Additionally, chest pain or pressure may be present, contributing to diagnostic confusion with cardiac conditions [10]. In more severe cases, especially when the stricture is pronounced, coughing or choking during or after swallowing may occur due to aspiration or impaired bolus passage [11].

3. Clinical and diagnostic differentiation between benign and malignant oesophageal strictures

Accurate differentiation between benign and malignant oesophageal strictures is essential for appropriate and timely management. Radiographic imaging, particularly barium swallow studies, often provide preliminary insight; benign strictures usually appear smooth and symmetric, while malignant ones may present with irregular, shouldered, or abrupt edges. Nevertheless, endoscopic examination with biopsy remains the gold standard for establishing a definitive diagnosis [12].

Benign oesophageal strictures frequently arise from chronic gastroesophageal reflux disease (GERD), which causes inflammation and subsequent scar tissue formation. Additional etiologies include prolonged nasogastric intubation, radiation therapy, ingestion of corrosive agents, and certain medications [13]. These strictures typically exhibit smooth, concentric, and gradually tapering narrowing of the oesophageal lumen. They are usually shorter in length and less likely to produce severe obstruction [14].

Clinically, patients with benign strictures may experience progressive dysphagia, initially to solid foods, along with pain on swallowing, occasional unintended weight loss, regurgitation of undigested food, and heartburn [7]. Barium swallow imaging typically reveals smooth, tapered areas of narrowing, while endoscopy not only confirms the diagnosis but also helps evaluate the stricture's severity and allows for therapeutic intervention [14]. Treatment generally includes endoscopic dilation and management of the underlying cause, such as acid suppression therapy in GERD [12].
In contrast, malignant oesophageal strictures are most commonly caused by oesophageal cancer, including squamous cell carcinoma and adenocarcinoma [13]. These strictures often appear irregular, asymmetric, and abruptly narrowed, with features such as nodular or ulcerated mucosa. They tend to be longer and cause more significant luminal obstruction [12].

Symptomatically, malignant strictures can mimic benign ones but typically demonstrate more rapid progression, with dysphagia advancing quickly from solids to liquids. Other notable features include substantial unintentional weight loss and pain behind the sternum or radiating to the back [7]. On imaging, malignant strictures may show shouldered or irregular contours, and endoscopy with biopsy is essential to establish the presence of malignancy [15]. Treatment is focused on oncologic management and may involve a combination of surgery, chemotherapy, radiation therapy, and palliative interventions such as oesophageal stenting to relieve obstruction and maintain oral intake [12].

In essence, benign oesophageal strictures tend to have a gradual onset and are often associated with a history of GERD or other chronic inflammatory

conditions [15]. In contrast, malignant strictures progress more rapidly, are commonly linked to underlying oesophageal carcinoma [10], and frequently present with additional systemic symptoms such as weight loss, chest pain, and hoarseness [15]. A summary of the key differences between benign and malignant oesophageal strictures is presented in Table 1.

Table 1. Key differences between Benign and Malignant oesophageal strictures

Feature	Benign Strictures	Malignant Strictures
Etiology	GERD, caustic injury, iatrogenic causes	Primary oesophageal cancer, metastasis
Onset	Gradual	Rapidly progressive
Symptoms	Dysphagia, rarely associated with weight loss.	Dysphagia with significant weight loss
Endoscopic Appearance	Smooth, concentric narrowing	Irregular, nodular, or ulcerative narrowing
Treatment	Dilation, medications, or dietary changes	Surgery, stenting, chemotherapy, or radiation
Prognosis	Generally favorable	Often poor, depending on cancer stage

4. Epidemiology of benign oesophageal strictures

Benign oesophageal strictures have an estimated incidence of approximately 8 per 100,000 individuals [16]. These strictures can occur across all age groups, but certain causes show age-specific patterns. For example, strictures due to caustic esophagitis or eosinophilic esophagitis are more commonly seen in children and young adults, while those related to chronic acid reflux or medication-induced esophagitis are more typical in adults. There is no definitive sex predilection; however, men are generally at higher risk than women for erosive esophagitis, which can contribute to stricture formation [17]. Ethnic variations are also observed, with peptic strictures being ten times more common in Whites than in Blacks or Asians [15]. In terms of etiology, GERD is the leading cause, accounting for approximately 46% of benign strictures, followed by strictures of unknown origin (14%) [15].

5. Epidemiology of malignant oesophageal strictures

Malignant oesophageal strictures are less common, with an incidence of around 3 per 100,000 individuals [18]. These strictures predominantly affect older adults, reflecting the age distribution of oesophageal cancer [17]. Geographic and regional differences are significant: squamous cell carcinoma is more prevalent in countries such as China and Iran, often attributed to tobacco and alcohol use, while adenocarcinoma is more frequently diagnosed in developed nations, where it is strongly associated with Barrett's oesophagus and chronic GERD [15].

6. General epidemiological insights and risk factors

Oesophageal strictures, in general, are relatively common, affecting approximately 1 in 100 to 1 in 1,000 individuals in the United States, with the highest prevalence seen in individuals over the age of 75 [19]. From a healthcare perspective, the economic impact of managing oesophageal strictures is considerable, with annual costs in the U.S. exceeding $1 billion [20].

Key risk factors for malignant oesophageal strictures include tobacco use, alcohol consumption (especially with squamous cell carcinoma), chronic GERD, Barrett's oesophagus, and obesity (notably in adenocarcinoma). Nutritional deficiencies, such as low intake of selenium and zinc, and exposure to nitrosamines also contribute to cancer risk. These epidemiological and etiological differences between benign and malignant oesophageal strictures are summarized in Table 2.

Table 2. Comparative epidemiological and etiological features of benign and malignant oesophageal strictures

Feature	Benign Strictures	Malignant Strictures
Etiology	GERD, caustic ingestion, surgery	Oesophageal cancer (SCC, adenocarcinoma)
Prevalence	70-80% of all strictures	20-30% of all strictures
Age of Onset	Typically >50 years	Typically >50 years, varies by type
Risk Factors	GERD, oesophageal injury	Tobacco, alcohol, Barrett's esophagus
Geographic Variation	Higher in developed nations (GERD)	SCC: Asia/Africa; Adeno: Western nations

7. Etiopathogenesis of benign and malignant oesophageal strictures

The development of oesophageal strictures—whether benign or malignant—stems from distinct pathological mechanisms rooted in their underlying etiologies. Benign oesophageal strictures commonly result from chronic inflammatory processes that lead to fibrosis and narrowing of the oesophageal lumen. One of the most prevalent causes is gastroesophageal reflux disease (GERD), where prolonged acid exposure induces mucosal injury and collagen deposition, ultimately resulting

in scarring and stricture formation [20]. Eosinophilic esophagitis (EoE) also plays a role, as this immune-mediated disorder leads to eosinophilic infiltration and tissue remodelling, contributing to oesophageal narrowing [21].

Additional benign causes include caustic ingestion, which produces direct chemical injury, and radiation therapy, which damages the oesophageal wall during cancer treatment in the thoracic region. Iatrogenic injury, such as that resulting from surgical or endoscopic procedures, and pill-induced esophagitis, linked to medications like bisphosphonates, NSAIDs, and tetracyclines, can also cause localized mucosal damage and subsequent fibrosis [22].

In contrast, malignant oesophageal strictures are caused by tumour growth, which leads to progressive luminal obstruction. The most common malignancies involved are oesophageal squamous cell carcinoma and adenocarcinoma, which invade the oesophageal wall and disrupt its architecture [15]. Barrett's oesophagus, a complication of long-standing GERD, is recognized as a precancerous condition that may progress to adenocarcinoma in the lower oesophagus. Additionally, adjacent tumours from the lung or mediastinum may cause extrinsic compression, while metastatic lesions from distant organs such as the stomach or lungs may secondarily involve the oesophagus, contributing to malignant stricturing [15]. While benign strictures typically evolve through fibrotic healing responses to injury, malignant strictures represent infiltrative tumour growth that distorts the oesophageal lumen and may also spread to regional tissues and lymphatics. The comparative etiological profiles of Benign and Malignant oesophageal strictures are outlined in Table 3.

Table 3. Comparative etiological profiles of benign and malignant Oesophageal strictures

Features	Benign Strictures	Malignant Strictures
Common Causes	GERD, injury, radiation, EoE	Primary oesophageal cancer (SCC, adenocarcinoma)
Inflammatory Causes	GERD, EoE	Barrett's esophagus (progressing to adenocarcinoma)
Trauma	Surgery, caustic ingestion, pill injury	Rarely trauma-related; often from tumor growth
Infections	Fungal or viral in immunocompromised hosts	Rare; associated with secondary involvement
Geographic Factors	Related to GERD (Western) or caustic ingestion (developing countries)	SCC: "Oesophageal cancer belt"; Adeno: Western nations

8. Dental implications of oesophageal strictures and associated conditions

Oesophageal strictures, particularly those arising from gastroesophageal reflux disease (GERD), have notable implications in dental practice. Chronic acid exposure in GERD can lead to dental erosion, characterized by the loss of enamel, increased tooth sensitivity, and heightened susceptibility to decay. Additionally, patients may present with halitosis and a burning sensation in the oral cavity, symptoms that can serve as early indicators of GERD [23].

In cases where oesophageal strictures are malignant, treatments such as chemotherapy and radiation therapy can exacerbate oral health issues. These therapies often result in xerostomia (dry mouth), mucositis, and an increased risk of dental caries due to reduced salivary flow and compromised oral mucosa. Radiation therapy, in particular, can lead to long-term complications like osteoradionecrosis and trismus, further complicating oral care [24-26]. Given these associations, dental professionals play a crucial role in the early detection of systemic conditions manifesting in the oral cavity and in the management of oral complications arising from treatments for oesophageal strictures. Regular dental evaluations and interdisciplinary collaboration are essential to ensure comprehensive care for affected patients.

9. Pathophysiological mechanisms of benign and malignant oesophageal strictures

The underlying pathophysiology of oesophageal strictures varies significantly between benign and malignant forms, primarily due to differences in the initiating insult and tissue response.

Benign oesophageal strictures typically result from prolonged or recurrent inflammation, which leads to fibrosis and scarring of the oesophageal mucosa. The most common mechanism involves chronic gastroesophageal reflux disease (GERD), where repeated exposure of the oesophageal lining to gastric acid induces mucosal injury. This damage triggers a healing response characterized by collagen deposition, ultimately resulting in luminal narrowing and stricture formation [15].

Another important cause is eosinophilic oesophagitis, an immune-mediated condition in which eosinophilic infiltration of the oesophageal epithelium leads to tissue remodelling and fibrotic

stricture development [15]. Additionally, iatrogenic injuries, including those from surgical interventions, radiation therapy, or endoscopic procedures, can damage the mucosal lining and promote scar tissue formation, contributing to benign stricture development [21].

In contrast, malignant oesophageal strictures originate from the uncontrolled proliferation of cancerous cells, most commonly from squamous cell carcinoma or adenocarcinoma. These malignant cells infiltrate the oesophageal wall and surrounding structures, producing a mass effect that leads to progressive luminal narrowing. Unlike benign strictures that are fibrotic in nature, malignant strictures result from tumour growth and invasion, which not only obstruct the oesophageal passage but may also involve surrounding tissues and metastasize [27]. Various pathophysiological characteristics of benign and malignant oesophagal strictures are presented in Table 4.

Table 4. Comparative pathophysiological characteristics of benign and malignant oesophageal strictures

Aspect	Benign Stricture	Malignant Stricture
Cause	Chronic inflammation or injury	Cancerous growth (adenocarcinoma or SCC)
Mechanism	Fibrosis and scarring	Tumor invasion and obstruction
Progression	Gradual narrowing	Progressive with potential metastasis
Appearance	Smooth, concentric narrowing	Irregular, eccentric narrowing
Reversibility	Partially reversible (e.g., dilation, PPI)	Irreversible; requires oncological therapy
Symptoms	Gradual dysphagia, primarily for solids	Rapidly progressive dysphagia, weight loss

10. Risk factors associated with benign and malignant oesophageal strictures

Oesophageal strictures, defined as abnormal narrowings of the oesophageal lumen, can be categorized into benign and malignant types, each with unique pathophysiological mechanisms and associated risk factors. Understanding these risk factors is essential for early identification, preventive strategies, and tailored management.

Benign oesophageal strictures typically arise from chronic inflammatory processes that result in fibrosis and luminal narrowing. The most prominent risk factor is gastroesophageal reflux disease (GERD), where continuous exposure to gastric acid causes mucosal damage, stimulating a healing response that includes collagen deposition and stricture formation [28]. Another important cause is eosinophilic esophagitis, a chronic allergic inflammatory condition in which eosinophils infiltrate the oesophageal lining, leading to remodelling and fibrosis.

Additional risk factors for benign strictures include iatrogenic causes, such as surgical interventions, radiation therapy, or endoscopic procedures, all of which may result in mucosal injury and scarring [21]. Medication-induced injury, particularly from commonly used drugs like nonsteroidal anti-inflammatory drugs (NSAIDs), has also been associated with an increased risk of oesophageal strictures [21]. Furthermore, caustic ingestion—either accidental or intentional—can cause direct chemical burns to the oesophageal lining, triggering a severe fibrotic response [21].

In contrast, malignant oesophageal strictures are primarily caused by oesophageal cancers, including squamous cell carcinoma and adenocarcinoma, and are associated with a distinct set of risk factors. Age is a significant contributor, with less than 15% of cases occurring in individuals under 55 years [29]. Gender also plays a role, with men being more frequently affected than women [30]. Lifestyle-related factors, such as tobacco smoking and heavy alcohol consumption, are strongly associated with squamous cell carcinoma [30].

Table 5. Comparative risk factors for benign and malignant oesophageal strictures

Category	Benign Strictures	Malignant Strictures
Inflammatory	GERD, EoE	Barrett's esophagus, GERD
Lifestyle	Smoking, alcohol, caustic ingestion	Smoking, alcohol, nitrosamine-rich diets
Surgical/Medical History	Post-surgery, radiation, or injury	Radiation therapy, achalasia, tylosis
Geographic Distribution	GERD in Western countries, caustic ingestion in developing regions	SCC in Asia/Africa; Adeno in Western nations
Congenital/Genetic	Congenital rings/webs	Tylosis, Plummer-Vinson syndrome

Obesity, particularly abdominal obesity, is a key risk factor for oesophageal adenocarcinoma [30]. Moreover, Barrett's oesophagus, a condition arising from chronic GERD that involves metaplastic changes in the oesophageal lining, significantly elevates the risk of progression to adenocarcinoma [31]. Additional dietary and systemic risk factors include low intake of fruits and vegetables, which may reduce protective antioxidant levels, and achalasia, a rare oesophageal motility disorder that impairs food clearance and increases the risk of malignancy [30]. The comparison of various risk

factors for benign and malignant strictures is summarised in Table 5.

11. Diagnostic modalities and imaging techniques for oesophageal strictures

The accurate diagnosis of oesophageal strictures—and the distinction between benign and malignant forms—relies on several essential diagnostic tools. One of the most informative procedures is upper gastrointestinal endoscopy, or esophagogastroduodenoscopy (EGD). This technique allows for direct visualization of the oesophageal mucosa, enabling clinicians to evaluate the location, shape, and appearance of the stricture. Additionally, it facilitates the collection of biopsy samples, which are critical for histopathological analysis, particularly in suspected cases of malignancy [30].

Another important diagnostic method is the barium swallow or oesophagram. In this procedure, the patient ingests a barium-containing contrast medium, followed by radiographic imaging of the oesophagus. This study can reveal structural abnormalities, and assist in differentiating benign from malignant strictures by analysing features such as stricture length, contour, tapering, and the presence of shouldering, a hallmark of malignancy [15].

In selected cases, particularly when malignancy is suspected, endoscopic ultrasonography (EUS) plays a valuable role. EUS provides high-resolution images of the oesophageal wall layers and surrounding tissues. It is especially useful for assessing the depth of tumour invasion and for evaluating regional lymph node involvement, both of which are important for staging oesophageal cancer and planning appropriate treatment [15].

In addition to endoscopic and contrast-based studies, cross-sectional imaging techniques like computed tomography (CT) and positron emission tomography-computed tomography (PET-CT) are valuable, especially in cases of suspected malignancy. PET-CT is particularly useful for detecting distant metastases and assessing the metabolic activity of tumours, aiding in staging and treatment planning. Although less commonly used, magnetic resonance imaging (MRI) may be employed in select cases where soft tissue delineation is essential or when contrast use must be avoided.

12. Treatment approaches for benign and malignant oesophageal strictures

The treatment of oesophageal strictures varies significantly depending on whether the underlying cause is benign or malignant, with therapeutic strategies tailored to the nature and severity of the condition.

Benign oesophageal strictures are typically managed with endoscopic dilation, which remains the primary therapeutic approach. Using a balloon or mechanical dilator, the narrowed segment of the oesophagus is gently stretched to alleviate obstruction and improve swallowing function [30]. When benign strictures are associated with gastroesophageal reflux disease (GERD), proton pump inhibitors (PPIs) are prescribed to reduce acid production, promote mucosal healing, and prevent recurrence [15]. In cases where infection is identified as a contributing factor, antibiotic or antifungal therapy may be necessary.

Surgical intervention is reserved for patients who exhibit recurrent or refractory strictures that do not respond adequately to conservative treatments. This may involve resection of the affected oesophageal segment and reconstruction [32]. In addition, management includes treating the underlying etiology, such as optimizing GERD control through pharmacologic and lifestyle modifications, which include weight management, avoiding alcohol and smoking, and refraining from lying down immediately after meals [33,34]. Nutritional support may be provided through dietary adjustments, such as adopting a soft or liquid diet, to ensure adequate intake and reduce swallowing discomfort [35].

For malignant oesophageal strictures, the primary goal of treatment is to relieve obstruction, manage cancer progression, and maintain nutritional status. Endoscopic dilation may offer temporary symptom relief while self-expanding metal stents are frequently placed to maintain oesophageal patency and facilitate oral intake [22]. Definitive oncologic treatment involves chemotherapy and radiation therapy, which can reduce tumour burden and improve dysphagia [22].

In selected cases, particularly when localized disease and good performance status are present, esophagectomy may be performed to surgically remove the tumour and re-establish oesophageal continuity [36]. As in benign cases, supportive care plays a vital role. Management of malnutrition,

coexisting infections, and treatment-related complications is essential to optimize outcomes. Nutritional interventions, such as enteral feeding via tubes or specialized diets, are often required during and after cancer therapy [36]. Additionally, lifestyle changes, including smoking cessation, alcohol avoidance, and adherence to medical guidance, contribute to improved overall health and treatment effectiveness. The major differences in treatment objectives, techniques, and supportive care measures for benign versus malignant oesophageal strictures are summarized in Table 6.

Table 6: Comparative overview of treatment strategies for benign and malignant oesophageal strictures

Aspect	Benign Oesophageal Strictures	Malignant Oesophageal Strictures
Primary Goal	Relieve obstruction and prevent recurrence	Relieve obstruction, manage cancer, and improve quality of life
Dilation	Frequent primary treatment; endoscopic dilation using balloons or dilators	Used for temporary relief; combined with stenting for prolonged patency
Stenting	Rarely required; used in refractory cases	Commonly used; self-expanding metal stents placed for palliation
Medications	PPIs for GERD; antimicrobials for infections	Chemotherapy and radiation therapy for cancer management
Surgery	Rarely needed; considered for refractory or complex strictures	Esophagectomy (partial or total) or palliative surgical interventions
Treating Underlying Causes	Essential; managing GERD, eosinophilic esophagitis, or infections	Secondary; focus on addressing cancer-related complications
Nutritional Support	Soft or liquid diets; temporary nutritional interventions	Enteral (feeding tube) or parenteral nutrition during treatment
Lifestyle Changes	GERD management: avoid alcohol, smoking, and lying down after meals	Cancer care: avoid tobacco, alcohol, and follow oncologist's recommendations
Prognosis	Generally excellent with treatment of underlying condition	Variable; depends on cancer stage and treatment response

13. Clinical manifestations of benign and malignant oesophageal strictures

The clinical presentation of oesophageal strictures varies depending on whether the underlying cause is benign or malignant, although both forms commonly affect swallowing.

Benign oesophageal strictures usually present with progressive dysphagia, beginning with difficulty swallowing solid foods and potentially advancing to liquids if untreated [37]. This is often accompanied by heartburn and regurgitation, particularly in patients with underlying gastroesophageal reflux disease (GERD), which is a common etiological factor [38]. Some individuals may also report chest discomfort or a sensation of food becoming lodged in the chest during meals [39]. In more advanced cases, unintentional weight loss may occur due to reduced oral intake caused by swallowing difficulties [39].

In contrast, malignant oesophageal strictures tend to present with more rapidly progressive dysphagia, typically evolving from solids to liquids over a matter of weeks or months [29]. A hallmark of malignant disease is significant unintentional weight loss, resulting from both dysphagia and the systemic metabolic impact of the malignancy [40]. Odynophagia, or pain during swallowing, is often more pronounced in malignant cases and may further limit dietary intake [29]. Involvement of the recurrent laryngeal nerve or the formation of a tracheoesophageal fistula can lead to hoarseness and persistent coughing [41]. Additionally, patients may experience chest pain or a burning pressure sensation, particularly if the tumour has infiltrated surrounding structures.

14. Conclusion

Oesophageal strictures, whether benign or malignant, significantly affect a patient's quality of life, causing dysphagia and other complications. Benign strictures are commonly caused by conditions like gastroesophageal reflux disease (GERD), eosinophilic esophagitis, or post-surgical scarring, and generally respond well to medical or endoscopic treatments. In contrast, malignant strictures, often linked to oesophageal cancer, typically signal a poor prognosis and require a combination of surgical, chemotherapeutic, and palliative approaches. Early differentiation between benign and malignant strictures is essential for appropriate management, with diagnostic tools such as endoscopy, barium swallow studies, and biopsy aiding accurate identification. While benign strictures are often treated effectively with dilation and acid suppression therapy, malignant ones necessitate a more aggressive, progressive treatment strategy. Ongoing advancements in endoscopic techniques and targeted therapies improve patient outcomes, but early detection and research remain crucial to enhancing treatment

strategies and survival, particularly for malignant strictures.

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