

Oesophageal Hematoma After Curry Meal

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Citation

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Abstract

Intramural oesophageal hematoma is a rare endoscopic diagnosis. It can be easily misdiagnosed as aortic dissection or a cardiac event. It may or may not be associated with oesophageal perforation. In majority of cases it can be managed conservatively. A high index of suspicion is required to request endoscopy. Here we present a case of oesophageal hematoma in a lady who was not on anti-platelet or anticoagulants. She presented with dysphagia and central chest pain.

CASE HISTORY

A 54-year-old woman presented to the accident and emergency department after eating chicken curry. While eating she suddenly developed dysphagia and severe central chest pain radiating to the back. It was accompanied by shortness of breath and few bouts of hematemesis. She had a background of mild dyspepsia for which she was taking omeprazole. There was no other significant past medical history or drug use. She was a non-smoker and had no risk factors for ischemic heart disease.

She was hemodynamically stable without any difference in blood pressure in both arms. There was no subcutaneous emphysema and the abdomen was soft with only mild epigastric tenderness. Cardiovascular and respiratory examinations were unremarkable. Laboratory investigations including full blood count, clotting screen, renal/liver function, and serum amylase) were within normal ranges. The repeat haemoglobin after few hours remained normal as well. An electrocardiogram, chest and abdominal radiographs were also normal.

Gastroscopy revealed a large intramural oesophageal hematoma extending from 22 to 36 centimetres from incisors (Fig 1 and 2).

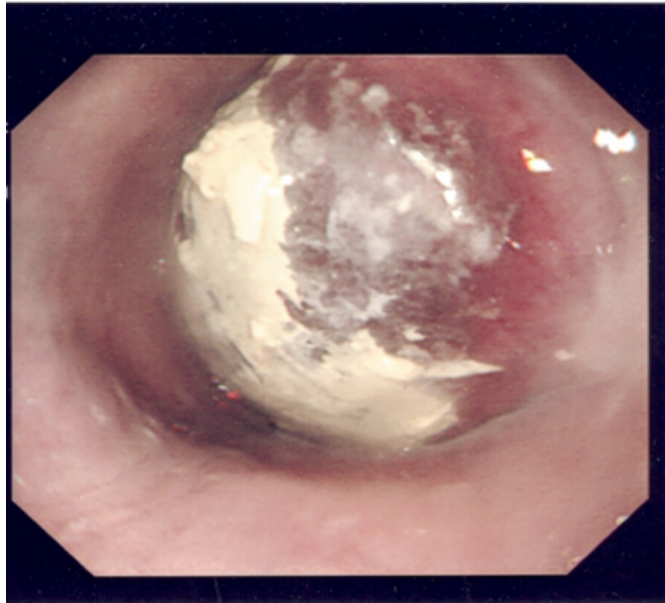
Figure 1

Figure 1



Figure 2

Figure 2



She then underwent a CT Scan of the chest which confirmed the presence of oesophageal hematoma without any perforation. The lumen was almost completely filled with a homogeneous tissue density extending from the level of the carina to the gastroesophageal junction.

The patient was treated conservatively with clear fluids and omeprazole and then slowly started on liquid diet. Her dysphagia settled and she was pain free in 3 days. She was discharged home on omeprazole.

A repeat gastroscopy at 4 weeks showed complete resolution of hematoma and patient was completely asymptomatic (Fig 3 and 4)

Figure 3

Figure 3

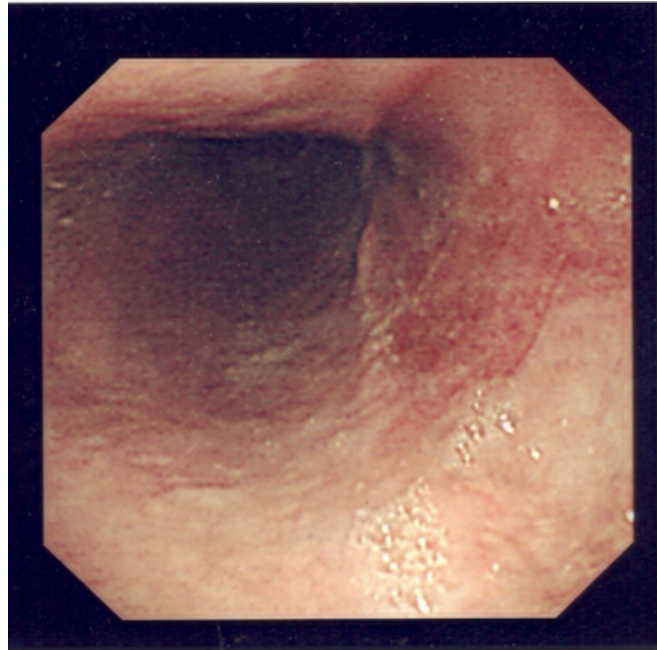
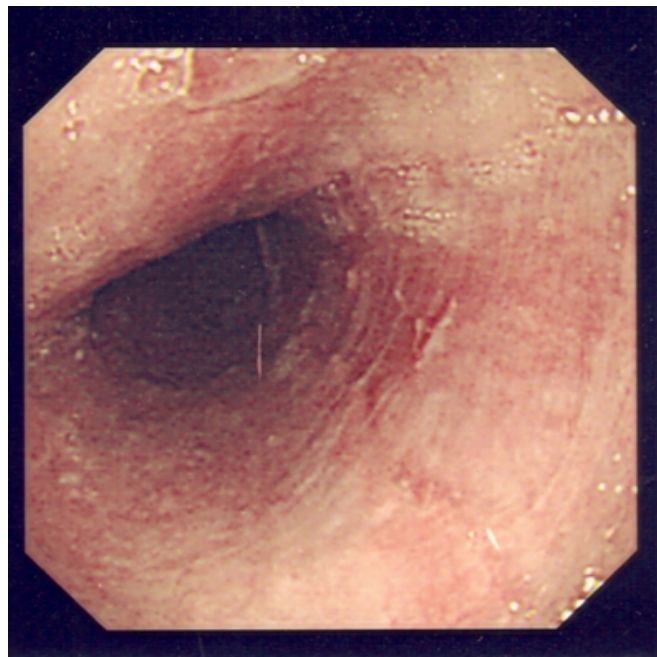


Figure 4

Figure 4



DISCUSSION

Oesophageal hematoma is being increasingly diagnosed because of wide availability of endoscopy service in almost all hospitals.

The causative factors include trauma, excessive retching, vomiting, endoscopic interventions or sometimes

spontaneous. Approximately 80% of intramural hematomas occur in women. Primarily middle-aged women are affected.

In a literature review of 31 patients, the mean age was 67 years^[1]. Oesophageal hematomas typically occur in the setting of vomiting or retching, although spontaneous hematomas (more commonly in patients with bleeding disorders) may also occur.

Presenting symptoms most commonly include dysphagia, hematemesis, and sub-sternal or epigastric pain.

It appears as raised purplish red lesions, mostly sub-mucosal in location, but occasionally obliterating the esophageal lumen.

The mechanism of development remains unclear. An intramural hemorrhage leads to a variable degree of submucosal dissection of the oesophageal wall ranging from single or multiple localized hematomas to complete dissection of the oesophagus.^[1]

Oesophageal hematomas can be further classified according to the degree of

involvement of the lumen in four stages (Table 1).

Table 1 Stages of oesophageal hematomas^[2]

I: Hematoma without surrounding tissue edema

II: Hematoma with surrounding tissue edema

III: Hematoma with edema plus compression of esophageal lumen

IV: Complete obliteration of the lumen with hematoma, edema, and organized clot formation

Extensive intramural hematomas have been demonstrated to develop in patients with bleeding diathesis or on anticoagulant.

It has been suggested that fiberoptic endoscopy is relatively contraindicated in the further evaluation of oesophageal hematoma because many intramural hematomas are

contained perforations that could be worsened by the insufflation of air.

Diagnosis can be safely made with upper GI endoscopy but if dysphagia or odynophagia is severe then radiological contrast imaging like barium and CT scan should be done first to exclude perforation.

Typically barium swallow or CT scan have been used for the diagnosis, showing intraluminal filling defects or a double-barrelled appearance of the oesophagus^[3]

It can closely mimic Mallory-Weiss tear and Boorhaave's syndrome if chest pain is accompanied with hematemesis.

Oesophageal hematomas generally have a benign course and resolve within three weeks of conservative management^[4].

A soft diet may be started in a stable patient on days 4-6. Parenteral feeding is generally not required, as most patients are able to swallow within a few days.

Follow-up care after the acute event has resolved with either a barium swallow or endoscopy is necessary to rule out any additional oesophageal disease not seen on the initial evaluation. This can be done prior to discharge or can be arranged to be done on an outpatient basis.

Full-thickness perforations of the esophageal wall have been reported during endoscopy of an esophageal hematoma.

References

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