CASE REPORT

Spontaneous Intramural Oesophageal Haematoma: A Case Report

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SUMMARY

Spontaneous intramural oesophageal haematoma is a rare disease and presents with the classic triad of symptoms of chest pain, dysphagia and haematemesis. Flexible oesophagoscopy and contrast enhanced CT scan is helpful in the diagnosis and also to exclude other sinister pathologies. Most are managed conservatively and the patient we report also was managed conservatively with a successful outcome.

INTRODUCTION

Spontaneous intramural oesophageal hematoma (IOH) is a rare disease and commonly presents with acute chest pain, dysphagia and haematemesis. An underlying predisposing factor such as anticoagulant or antiplatelet treatment, instrumentation, trauma, or foreign body ingestion is found in the majority of cases[1,2,3]. Although it has mostly a benign course, the dramatic presentation necessitates exclusion of more serious conditions such as aortic dissection and myocardial infarction. We present a case of a patient presented with haematemesis and dysphagia subsequently diagnosed as spontaneous intramural oesophageal hematoma.

CASE REPORT

A 63 year old female patient presented with three episodes of haematemesis associated with acute onset dysphagia and odynophagia. She had a history of hypertension and ischemic heart disease and was on antihypertensive medication with aspirin. She was initially admitted to the local hospital where she has undergone a flexible oesophagoscopy which showed a large submucosal haematoma. She was referred to our unit with the suspicion of an aorto-oesophageal fistula.

On admission the patient was haemodynamically stable with a blood pressure of 120/70 mmHg and a pulse rate of 80 beats per minute. Haemoglobin was 11.2 g/dl and the platelet count was 234000/mm^3. Prothrombin ratio was normal with a value of 1.1.

A repeat flexible oesophagoscopy confirmed the large submocosal haematoma along the posterior oesophageal wall extending from 4cm distal to cricopharyngeal sphincter up to the gastro-oesophageal junction (Figure 1). A contrast enhanced helical CT scan of the chest showed the long segmental, eccentric, submucosal, hyperdense lesion suggestive of an oesophageal haematoma without any evidence of an aorto-oesophageal fistula (Figures 2).

The patient was managed conservatively with a liquid diet, intravenous antibiotics and proton pump inhibitors after stopping aspirin treatment. The patient had an uneventful recovery and the dysphagia and odynophagia completely resolved over 5 days. A repeat flexible oesophagoscopy performed three weeks later was completely normal without any evidence of a previous haematoma.

DISCUSSION

IOH is a rare condition associated with the dissection of the mucosa from the muscular layer. Possible predisposing factors for an IOH include abnormal haemostasis, forceful emesis, traumatic (blunt trauma or food-induced trauma), iatrogenic (i.e. complications of central venous catheter insertion or endoscopic procedures) and related to aortic disease[1].

The classic triad of haematemesis, retrosternal pain and dysphagia / odynophagia is seen only in about 35% of patients with an IOH, although at least two of the triad is seen in 80%. As their presentations primarily include acute chest pain, spontaneous oesophageal injuries are easily misdiagnosed in the emergency department as acute myocardial infarction, acute aortic dissection, aortic aneurysm rupture, perforated peptic ulcer or acute pancreatitis. The condition is nearly twice as common in females compared to males (1.8:1) and occurs in middle aged patients[3].

Anatomically the haematoma is commonly identified in the distal oesophagus as this is the area least supported by the adjacent structures, the heart and trachea. The haematoma is located submucosally due to the weak attachment of the mucosa to the underlying muscularis propia[4].

Computed tomography (CT) scanning is sensitive and specific in the diagnosis of IOH, and helps to exclude other sinister pathologies such as aortic dissection, ruptured thoracic aortic aneurysm or aorto-oesophageal fistula. The characteristic CT finding is a concentric or eccentric high attenuated oesophageal wall thickening with well-defined borders and variable degree of obliteration of the lumen[5]. The endoscopic findings are typical with a blue submucosal

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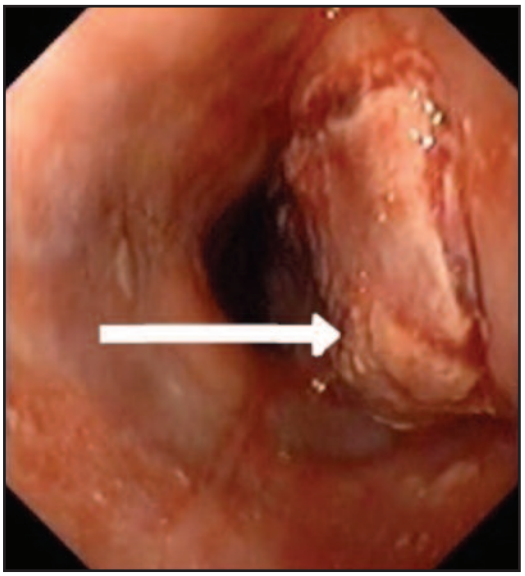

Fig. 1 : Flexible oesophagoscopy showing the large submocosal haematoma (arrow) along the posterior oesophageal wall

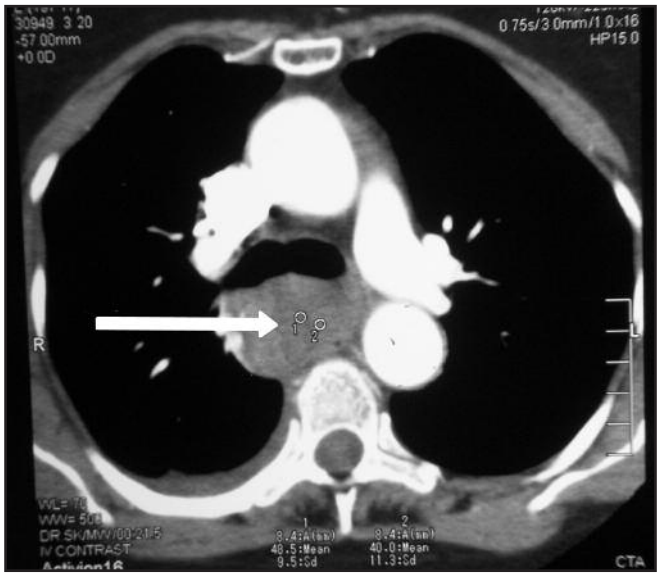

Fig. 2 : Contrast enhanced helical CT scan of the chest showing the eccentric, submucosal, hyperdense lesion suggestive of an oesophageal haematoma

haematoma bulging into the oesophageal mucosa extending a variable length. Endoscopic ultrasound is an excellent tool to confirm the submucosal haematoma, but the probe is placed blind and may traumatise the oesophagus.

The prognosis of an intramural hematoma is good. Once the diagnosis is confirmed conservative and supportive care remains the main therapeutic modality, and most hematomas resolve spontaneously as was seen in the patient reported here. Severe bleeding or oesophageal perforations are rare complications of IOH[2]. Exclusion of other life threatening conditions such as aortic dissection or aorto-oesophageal fistula remains crucial since delayed diagnosis and treatment in such situations carry a grave prognosis.

REFERENCES

1. Ashman FC, Hill MC, Saba GP, Diaconis JN. Esophageal hematoma associated with thrombocytopenia. Gastrointest Radiol 1978; 25: 115-8.
2. Cullen SN, McIntyre AS. Dissecting intramural haematoma of the oesophagus. Eur J Gastroenterol Hepatol 2000; 12: 1151-62.
3. Kerr WF. Spontaneous intramural rupture and intramural haematoma of the oesophagus. Thorax 1980; 35(12): 890-7.
4. Mion F, Bernard G, Valette PJ, Lambert R. Spontaneous esophageal hematoma: diagnostic ontribution of echoendoscopy. Gastrointest Endosc. 1994; 40: 503-5.
5. Meininger M, Bains M, Yusuf S, Gerdes H. Esophageal intramural hematoma: a painful condition that may mimic an esophageal mass. Gastrointest Endosc 2002; 56: 767-70.