Question 43 – June 2

1. A 61 year old woman with history of hypertension, diabetes, coronary artery disease and recently with an upper respiratory infection presents with the sudden onset of nausea, hematemesis, dysphagia and retrosternal chest pain. The pain is 3/10 in intensity and non-radiating. There have been no recent bowel movements and the patient has not noticed whether her stools have recently been dark or black in color. Her bloodwork showed a normal hemoglobin and normal BUN. In the emergency room the patient remained hemodynamically stable only vomiting twice with small amounts of blood in the emesis. The emergency room performed a CT of the chest, abdomen and pelvis showing a diffusely thickened esophagus with complete obliteration of the distal esophageal lumen. An endoscopy shows a long, deep friable blue appearing mass in the distal esophagus that obliterates the lumen in the distal esophagus. What is the most appropriate next step in management of this patient?

A. Refer to surgery for resection
B. Repeat CT scan in one week
C. Endoscopic mucosal resection
D. Radiofrequency ablation

Answer: B

The patient most likely has a spontaneous esophageal hematoma. This is most commonly seen in women. She has coronary artery disease and is likely on ASA chronically which also is a risk factor for this diagnosis. About 50% of patients present with the classic triad of retrosternal chest pain, dysphagia and hematemesis. It is usually triggered by recurrent vomiting or sneezing. In this case, the patient has a recent upper respiratory tract infection. The best management of this diagnosis is conservative measures with repeat imaging in one week.

References:

1. Enns R, Brown JA, Halparin L: Intramural esophageal hematoma: A diagnostic dilemma. *Gastrointest Endosc* 2000; 51:757-759