Intramural Hematoma of Esophagus

Hardik L Kotecha¹, Mandhir Kumar¹, DS Rana²

¹Department of Gastroenterology and Hepatology, and ²Department of Nephrology, Sir Ganga Ram Hospital, New Delhi, India

ABSTRACT

Intramural hematoma of the esophagus is the least common form of traumatic injuries of the esophagus. It can be spontaneous or secondary. The classic triad of presentation includes chest pain, dysphagia and hematemesis. Most of cases are diagnosed by endoscopy, with various other modalities like barium swallow, CT scan or endo-ultrasound acting as complimentary investigative tools. The management is conservative in most cases. We report a 56-year-old woman with intramural hematoma of esophagus induced by retching. (J Dig Endosc 2012;3(1):19-21)

Key Words: Intramural hematoma - Esophagus - Upper GI endoscopy - Endoultrasound

Introduction

Traumatic esophageal injuries may present in the form of mucosal tears (Mallory Weiss tear), esophageal rupture (Boerhaave’s syndrome) and rarely as intramural hematoma. The term esophageal apoplexy was coined by Smith et al [1] in 1974 for spontaneous intramural hematoma of esophagus. Intramural hematoma of esophagus may occur spontaneously (in presence of predisposing factors) or secondary to trauma following vomiting, retching[2], cardio version or blunt chest trauma, caustic ingestion, food laceration[3], endoscopy and intervention like esophageal sclerotherapy [4], or endotracheal intubation[5]. The predisposing factors include patients on anticoagulants[6], aspirin or coagulopathies like hemophilia and thrombocytopenia[7].

Case Report

A 56-year-old lady presented with history of sudden onset, retrosternal chest pain associated with epigastric pain preceded by vomiting and retching for the past 1 day. She also complained of odynophagia and 2 episodes of hematemesis. She had a history of systemic hypertension for 12 years and chronic renal failure due to hypertensive nephropathy on maintenance hemodialysis for 2 years. On admission she had a resting tachycardia with heart rate of 110 beats/min, and blood pressure of 148/84 mmHg. She had pallor and was in obvious distress because of pain. Her systemic examination was unremarkable. Investigation done showed low hemoglobin 8.9gm/dl, normal white cell count 5,400 cells/cmm, and platelet count 2.45 lac/cmm. Her prothrombin time was normal with INR (International normalized ratio) of 1.07. Her serum creatinine was 11.39 mg/dl (normal <1.2 mg/dl) with normal electrolytes. Her liver function tests were normal. An esophagogastro-duodenoscopy done showed large violet colored swelling in the esophageal wall extending from the cricopharynx up to the level of esophagogastric junction (Figures 1 and 2) with a linear tear of the mucosa just above the esophagogastric junction (Figure 3). A diagnosis of intramural hematoma induced by retching and vomiting was made. Patient was kept nil by mouth and treated with intravenous fluids, pantoprazole, metoclopramide,
endoscopy done after 15 days showed complete resolution of the hematoma with healed tear at the lower end of esophagus (Figures 4 and 5).

**Discussion**

The classical triad of chest pain, dysphagia and hematemesis is present in 35% of patients [8] of intramural hematoma of esophagus but atleast one of the symptoms is present in 99% of patients. The other presenting symptoms are odynophagia and epigastric pain. The differential diagnosis include various cardiovascular and gastrointestinal disorders, esophageal varices or a mass lesion with luminal compression suggestive of malignancy [1]. The entity is twice as common in females compared to males and most commonly seen in middle aged and elderly women as opposed to Mallory Weiss tear and Boerhaave’s syndrome which are more common in males[9]. It has been suggested that in patients with normal coagulation profile the hematomas have a predilection for the distal esophagus probably precipitated by sheering forces of vomiting or retching and in those with abnormal coagulation hematomas arose in the proximal esophagus or are multiple[10]. In

antihypertensives and maintenance hemodialysis. Her pain subsided in 48 hours and she was started on oral liquids on 4th day of admission followed by solid diet gradually. A repeat
Barium studies a “double barrel” sign is occasionally seen due to the false lumen[11,12]. CT scan shows an esophageal mass with density similar to blood[11]. Endoscopy will show a smooth violaceous appearing esophageal wall with extrinsic compression and endo-ultrasound is also being used to diagnose the entity. Treatment of esophageal hematoma is conservative in most cases, surgery is required in around 15% of patients only[10,13,14].

References


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