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A case oesophageal haematoma masquerading as esophageal tumor

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Abstract

Intramural esophageal hematoma is relatively a rare form of esophageal injury. The presentation is varied and many patients may be asymptomatic. Evaluation with Esophagogastroscopy and computed tomography scan are usually needed to establish the diagnosis. Here we report a case of oesophageal haematoma in which endoscopic appearances initially had suggested a lower esophageal growth but on subsequent evaluation turned out to be a esophageal hematoma secondary to Mallory Weiss tear.

Keywords

esophageal hematoma; injury; hemorrhage; mallory weiss tear

Abbreviations

OGJ: oesophagogastric junction; CECT: contrast enhanced computerized tomography; GI: gastrointestinal; INR-international normalized ratio

Introduction

Intramural esophageal hematoma sometimes also referred as esophageal apoplexy, is thought usually be due to esophageal injury such as following Mallory-Weiss tear and Boerhaave syndrome [1,2]. The majority of cases of intramural esophageal hematoma have predisposing factors such as coagulopathy [3,4], instrumentation [5], trauma [6], or foreign body ingestion [7]. The diagnosis of spontaneous intramural esophageal hematoma is usually delayed probably due to his benign course, until other more serious conditions have been excluded. Early diagnosis may be difficult because of non-specific presentation. Here we are presenting a case of esophageal hematoma, initially thought as tumor, later on treated conservatively.

Case Presentation

A 54 year old male was admitted in our hospital with four episodes of coffee colored vomitus. He also gave history of passing black tarry stools since 1 day. He had no history of dysphagia, chest or abdominal pain, weight loss. Patient was known case of rheumatic heart disease and was taking acenocoumarol (1mg) daily for paroxysmal atrial fibrillation and mitral valve replacement (St. Jude's Mechanical valve). On clinical examination, he was hemodynamically stable with a blood pressure of 110/70 mm Hg. Patient was pale. Lab investigations showed hemoglobin of 8.8 g/dl and INR was 2. Platelet count and liver function test were normal. For evaluation of upper gastrointestinal bleed, gastroscopy was done which showed a large vascular polypoidal growth like lesion around 3x3 cm in the distal esophagus near OG junction (Figure 1). Esophageal malignancy was suspected but biopsy was deferred in view of recent GI Bleed and elevated INR. Acenocoumarol was withheld and heparin infusion was started. Further plan was to take biopsy from the lesion and Endoscopic Ultrasound (EUS) for staging purpose. Repeat esophagogastroscopy after 3 days showed the growth like lesion had completely disappeared and instead mildly thickened edematous mucosa with Mallory Weiss tear and possible fistulous communication noted at OGJ. CECT with oral contrast revealed irregular wall thickening of 8 mm thickness extending for about 2 cm in length at OG junction with ulcer in posterior aspect of OG junction (Figure 4). Patient was put on high dose proton pump inhibitors and relook esophagogastroscopy done after 6 weeks revealed completely normal mucosa at the OG junction (Figure 3). He is under follow up with us and currently asymptomatic for any GI issues.

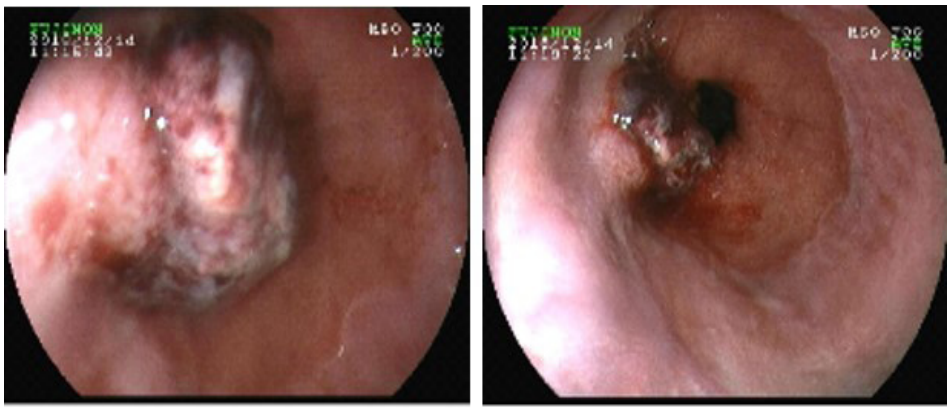

Figure1: Endoscopic picture showing growth like lesion at OG junction.

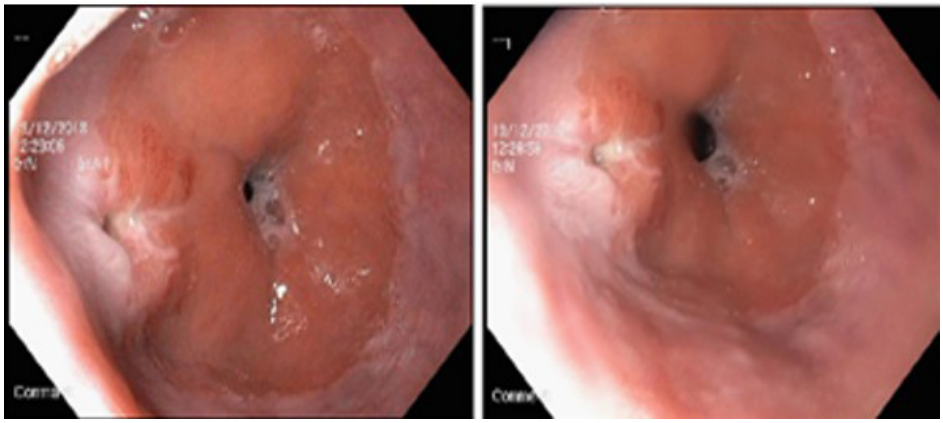

Figure 2: Endoscopy done after 72 hours showing mucosal tear with resolving edema compared to figure 1.

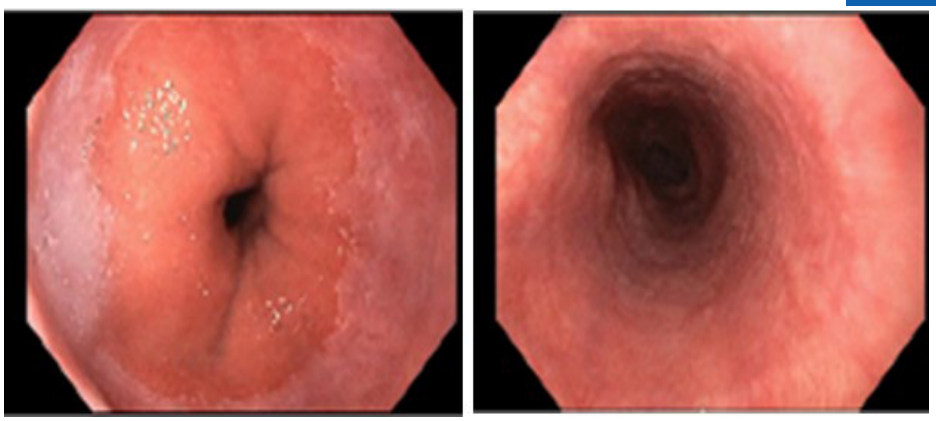

Figure 3: Endoscopy done after 6 weeks showing complete resolution of hematoma.

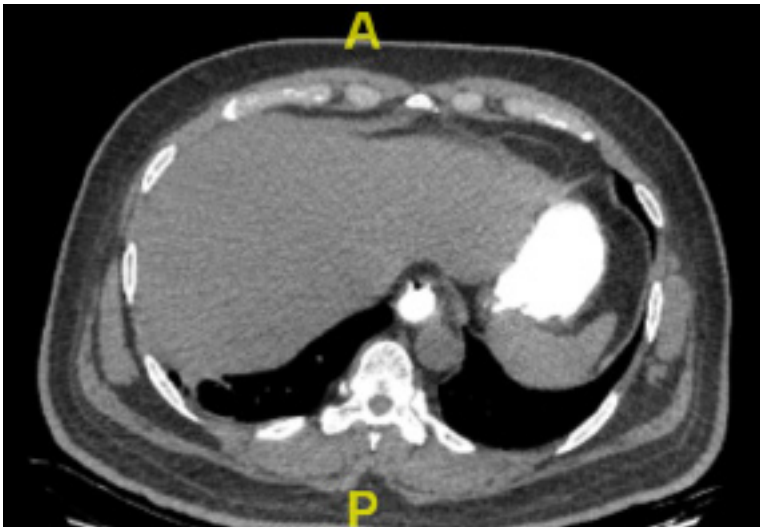

Figure 4: Computarized Tomography abdomen revealed irregular wall thickening at OG junction with ulcer in posterior aspect of OG junction

Discussion

Esophageal hematomas are an uncommon form of an esophageal injury. Oesophageal mucosal trauma and impaired haemostasis are the two important factors involved in the pathogenesis of esophageal hematoma formation. In the literature it has also been described as esophageal apoplexy, intramural hemorrhage and intramural dissection. It may occur following an esophageal dilation procedure [8,9]. It is usually found in elderly patients who are on antiplatelets and anticoagulants. With an increasingly older population who have cardiovascular risks on anticoagulation, it is essential to recognize and diagnose this condition early. Mallory-Weiss tear could be a possible cause of esophageal hematoma. This is suggested by the predominantly distal location of oesophageal haematomas and prodromal symptoms consistent with Mallory-Weiss tear.

The most common presenting symptoms are chest pain and/or hematemesis. The triad of chest pain, dysphagia and hematemesis is present in 35% of patients. Other symptoms may include epigastric pain and odynophagia. Since the presenting symptoms are nonspecific and the condition itself is rare, other cardiovascular and gastrointestinal conditions are usually considered before the diagnosis is established [9-11]. It can mimic esophageal varices when present as longitudinal vascular lesion or even as malignancy when present as mass lesion with luminal narrowing, on endoscopic examination [12]. A CT scan may

detect an intraluminal or intramural soft tissue density. The examination of choice is upper gastrointestinal endoscopy. Endoscopic ultrasound may also be helpful in establishing the diagnosis. Esophageal hematoma usually has benign course and resolve within three weeks of conservative management [13]. It is important to recognize the characteristic appearance as the management is usually conservative, unlike for varices or esophageal tumor. The patient in this case report was managed conservatively. Repeat endoscopy at 6 weeks showed complete resolution of hematoma.

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