Spontaneous haematoma of the oesophagus

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Abstract

Haematoma of the oesophagus is a rare occurrence and is usually in response to trauma, retching or vomiting. We report a case of spontaneous haematoma of the oesophagus that presented with only bruising over the chest. It resolved completely with conservative management. We review the literature, common causes, the differential diagnosis and the management of oesophageal haematoma.

Keywords: Oesophageal haematoma; Spontaneous

1. Case report

A fifty-year-old woman presented with superficial bruising over the manubrium, retro-sternal discomfort and difficulty swallowing solids, then liquids. There was no history of trauma, and no significant past medical history. She had not been on anti-platelet drugs or anti-coagulants. The blood pressure was normal and the bruise was the only significant finding. There was a neutrophilia (16.0 × 10^9 mm^-3) and no coagulation disorder. She was assessed as having an upper respiratory tract infection and was discharged.

Twelve hours later the patient returned because the bruising had spread to cover the entire anterior chest (Fig. 1). She now had no pain or dysphagia and was feeling well. The oropharynx was swollen and bruised. There were no other significant findings. Chest radiograph showed a widened superior mediastinum. Computer tomography (Fig. 2) demonstrated an intramural swelling of the entire oesophagus that pushed the trachea anteriorly. The swelling also extended into the neck and into the right carotid sheath. The mucosa did not appear involved. Neither CT nor contrast magnetic resonance angiography (MRA) could demonstrate a vascular defect responsible for the haematoma. Doppler ultrasound scan of both carotid arteries was normal. Gastrogaffin swallow demonstrated normal oesophageal structure and motility. Oesophagoscopy demonstrated only bruising and swelling of the oropharynx.

The diagnosis of spontaneous intramural haematoma of the oesophagus was made. The patient did not experience any discomfort and the bruising gradually resolved. Management was conservative. A repeat CT scan 4 months later appeared normal with no evidence of the previous bleeding.

2. Discussion

The presentation with severe spontaneous bruising was dramatic. Even more dramatic was the paucity of other significant signs or symptoms. The presence on X-ray of a widened mediastinal shadow and the suspicion of a vascular injury necessitated that a vigorous search for a bleeding source be conducted. CT and MRA [1] delineated the extent of the haematoma but could not locate the vascular lesion. Aortography is still considered as the ‘gold-standard’ investigation for aortic injuries because of the ability to demonstrate extravasation of contrast material, but is not without the small (but real) risk of causing new or further injury. We considered this option but the consensus was that MRA would be adequately sensitive with none of the risks of the more invasive procedure. MRA has the additional benefit of giving information regarding vessel wall lesions (e.g. plaque).

The differential diagnosis of oesophageal haematoma includes vascular injury, bronchial carcinoma, retro-sternal...
goiter, parathyroid adenoma, aortic aneurysm and mediastinal cyst. The significance of any one of these conditions demands that the patient is thoroughly investigated. Surgery plays a large part in the management of most of them. Vascular lesions such as aortic plaque rupture [2,3] require accurate delineation of the relevant anatomy to decide the most appropriate approach. If no vascular lesion can be demonstrated surgical exploration of a haemomediastinum would be difficult to justify because of the attendant risks.

In this case a small mediastinal vessel appears to have ruptured resulting in a haemomediastinum. This spread along tissue plains to involve the entire oesophagus, into the carotid sheath and extravasated into the subcutaneous tissue over the anterior neck and chest wall, presenting as painless bruising. The case was clinically designated as a spontaneous haematoma affecting the oesophagus because of the presence of pharyngeal bruising and circumferential thickening of the oesophagus. Haematoma of the oesophagus has long been recognized as rare [4] and has a spectrum of presentations [5], usually dependent on the extent of the lesion. A rapid change in intra-thoracic pressure associated with trauma, coughing, retching or sneezing often precipitates haematemesis, chest pain or dysphagia. Bleeding is more likely to occur in patients on anti-coagulants, anti-platelet drugs and who suffer from hypertension. This was not the case here. Intramural bleeding can extend beneath the submucosa and be severe enough to cause oesophageal dissection [6]. Boisserie et al. [5] in the largest review of similar lesions suggest that in most cases conservative management was uncomplicated. Surgery was associated with significant risk.

This case illustrates the wide spectrum of disease presentation and the need to accurately delineate the anatomy and pathology of the lesion before entering appropriate management.

References