Intramural esophageal dissection caused by upper endoscopy

A 21-year-old woman presented with antiphospholipid syndrome, chronic Budd–Chiari syndrome, portal vein thrombosis and Child C cirrhosis. Her medical history included variceal hemorrhage requiring endoscopic variceal ligation, hepatic encephalopathy and spontaneous bacterial peritonitis.

At a subsequent session of variceal band ligation, her vital signs were normal. Laboratory results included hemoglobin 8.7 g/l, platelet count 66 x 10^9/l, creatinine 0.73 mg/dl, total bilirubin 3.89 mg/dl, albumin 2.5 g/dl and International Normalized Ratio 1.5. Physical examination showed ascites, hepatomegaly and splenomegaly. During endoscopy a mucosal tear of 5 mm occurred at the gastroesophageal junction, resulting in active bleeding that required an adrenaline injection. The needle caused an esophageal perforation. Bleeding was not controlled, requiring the placement of a Sengstaken–Blakemore tube. She was evaluated by computed tomography of the chest. The coronal view showed an intramural esophageal dissection extending through the entire length of the proximal and mid-esophagus (Figure 1). Conservative treatment was initiated, which consisted of nil by mouth, administration of intravenous fluid, piperacillin-tazobactam and total parenteral nutrition. One week later, a barium swallow showed no esophageal leak, and the patient resumed oral nutrition. She was discharged 10 days later and placed on the waiting list for a liver transplant.

Intramural esophageal dissection, in which the esophageal mucosa becomes separated from underlying tissue, is an uncommon clinical condition characterized by a mucosal tear and intramural extension of a false lumen. Its exact etiology is uncertain, but most cases fall into three main subgroups: a sudden change in pressure within the esophagus, traumatic events or idiopathic. Computed tomography is the ideal investigative modality, with high specificity for an accurate diagnosis. Esophageal perforation may be associated with intramural esophageal dissection. Conservative management, including intravenous fluids, parenteral nutrition, anti-emetic therapy and proton pump inhibitors, should be initiated. Surgical treatment is required for complicated cases.

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References