Final diagnosis

Thoracic actinomycosis.

Keywords: actinomycosis; thoracic wall; anaerobes; abscess


Haematemesis and chest pain in a middle-aged woman

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A 57-year-old woman presented with acute-onset sharp retrosternal chest pain which occurred whilst walking. The pain radiated to her back and was associated with coffee-ground vomiting. She had eaten a meal two hours before with no discomfort. There was no previous history of ischaemic heart disease, hypertension, peptic ulcer disease or gastro-oesophageal reflux disease and she was not taking aspirin or any other nonsteroidal anti-inflammatory drug.

On examination she was well and had no surgical emphysema. The pulse was 90 beats/min and the blood pressure 150/85 mmHg being equal in both arms. The respiratory and abdominal system were unremarkable. Routine biochemical and haematological parameters were normal apart from a haemoglobin of 11.8 g/dl and a mean corpuscular volume of 88 fl. Her C-reactive protein (CRP) was 28 mg/l. The chest X-ray and electrocardiogram were normal. She was then kept nil by mouth and intravenous fluids were started. She then had an urgent oesophagogastroduodenoscopy which showed a submucosal haematoma extending from 18–40 cm (figure 1). On retroversion of the endoscope there was an ulcerative area at the cardia, histology of which showed fibrous debris but no evidence of malignancy. Computed tomography (CT) scan of the thorax showed a dilated proximal oesophagus with oesophageal wall thickening which narrowed to the level of the left pulmonary artery but no evidence of pathological lymph nodes or masses.

Questions

1 What is the diagnosis?
2 What is the treatment?

Figure 1 (A) Proximal portion of haematoma at 20 cm; (B) view at 35 cm; (C) distal portion at 40 cm; (D) ulcerative area seen on retroverting the endoscope.

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Answers

QUESTION 1
Oesophageal apoplexy.

QUESTION 2
The treatment of oesophageal apoplexy is conservative. This involves keeping the patient nil by mouth, instituting intravenous fluids and occasionally the use of blood transfusions. Acid suppression is empirically carried out with H2 antagonists, such as ranitidine. This should theoretically decrease acid reflux and aid healing of the oesophageal mucosa. Antibiotics should be considered if there is a fever. Surgical intervention is often fruitless and occasionally hazardous.1 Such a conservative treatment approach was instigated in our patient, who made a full recovery (figure 2).

![Figure 2](image-url)

**Discussion**

Oesophageal apoplexy is a term used to describe the development of a spontaneous intramural haematoma of the oesophagus. This leads to varying degrees of submucosal dissection of the oesophageal wall. The term was first coined by Tally and Nicks in 1969 but the condition itself was first described by Marks and Keat in 1968. This is a rare condition, commonly presenting in women over 50 years old, as in this case. However there have been some case reports of this condition occurring in younger patients.1

The most common presentation is with sharp retrosternal chest pain which may radiate to the back. Haematemesis is the next most common presentation occurring in 70% of patients and is often of small volume. There have been case reports where blood transfusions have been required but this is rare.1 Patients may also present with acute dysphagia and odynophagia.

The aetiology of this condition is unclear, although three possible theories have been put forward. The first is that there is submucosal haemorrhage due to a possible vascular abnormality. To support this theory oesophageal apoplexy has been associated with cavo-capsular ahaemangiomatosis. Another possibility is that oesophageal apoplexy lies on a spectrum between Mallory-Weiss syndrome and Bornholm’s disease. This is unlikely though, as these two conditions are both associated with profuse vomiting prior to developing other symptoms. An abnormal swallowing mechanism has also been suggested as there has been an association with symptoms occurring after eating and drinking but manometry performed in these patients has been reported as normal. In our case, it was interesting that the CRP was raised and this suggests a possible association with infection. Associations with upper respiratory tract infections have been described in other case reports.4 The other possibility is that this CRP rise is due to the large submucosal bleed.

When the diagnosis is missed, the management of the presumed diagnosis is often more aggressive. This is well illustrated in the literature. In one case, an endoscopist mistakenly performed an oesophageal biopsy, which led to severe gastrointestinal bleeding requiring an emergency oesophagectomy.5 Another reported misdiagnosis was a dissecting aortic aneurysm, which resulted in a left lateral thoracotomy being performed.6 A further report describes a patient who was diagnosed with an oesophageal carcinoma7 and told to ‘put his house in order’, the diagnosis being based purely on a CT scan. The main reason for misdiagnosis is that oesophageal apoplexy is a rare condition and endoscopists may not recognise the classical appearance. Another problem is that it mimics common emergencies such as aortic dissection, Bornholm’s disease and oesophageal malignancy.

**Final diagnosis**

Oesophageal apoplexy.

**Keywords:** oesophageal apoplexy; endoscopy; haematemesis; chest pain

Summary points

- Oesophageal apoplexy is a rare cause of haematemesis and chest pain which can be treated conservatively.
- Endoscopy is a useful way of confirming the diagnosis.