An unusual cause of an upper gastrointestinal bleed

Introduction

Oesophageal haematoma is an unusual condition which can present with symptoms of an upper gastrointestinal bleed. It can either be spontaneous or secondary to many reasons. This article reports a case of spontaneous oesophageal haematoma which was managed conservatively, and discusses the aetiology, clinical features and management of this rare condition.

Discussion

Oesophageal haematoma can be a part of the spectrum of oesophageal injury and is an uncommon condition affecting all ages. The clinical presentation of this condition can be variable. Although usually asymptomatic, it may present with retrosternal pain with or without radiation, haematemeis, dysphagia or odynophagia. Severe retrosternal pain can be the main symptom of dissecting oesophageal haematoma. It is important to distinguish intramural dissection from a cardiac event because anticoagulation will worsen the oesophageal haematoma (Vyas et al, 2004). Depending on their aetiology, oesophageal haematomas can be classified as spontaneous or traumatic (Ouatu-Lascar et al, 2000) (*Table 1*). Known risk factors include advancing age, bleeding disorders, and the use of anticoagulant, antiplatelet or thrombolytic drugs (McGurk et al, 2001).

Table 1. Causes of oesophageal haematoma

Spontaneous	Associated with coughing, retching, protracted vomiting
	Oesophageal barotraumas
	Pill-induced oesophageal injury
	Use of anticoagulants or aspirin
	Oesophageal diverticulum
	Arteriovenous malformation
Traumatic	Endoscopic intubation, biopsy, dilatation
	Variceal sclerotherapy
	Transoesophageal echocardiography
	Foreign body ingestion

From Ouatu-Lascar et al (2000)

Figure 1. Endoscopic view of oesophageal haematoma.

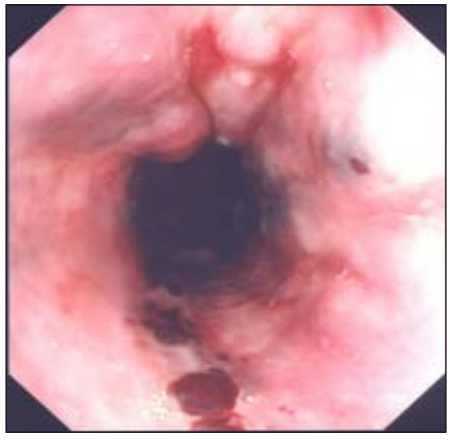
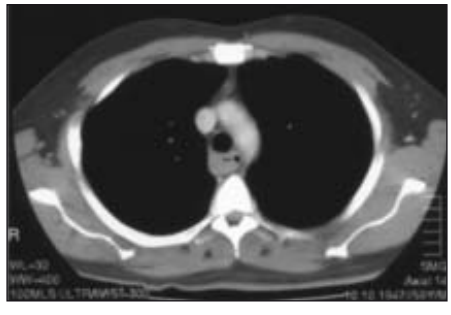


Figure 2. Computed tomography scan demonstrating oesophageal haematoma.



Chest X-ray may show a widened mediastinum or bilateral pleural effusions in case of an oesophageal perforation. Barium study may reveal the 'double barrel' sign which reflects a mucosal tear which allows escape of contrast material into the haematoma. Computed tomography is helpful to exclude other differential diagnoses presenting with similar symptoms such as a tumour, aortic dissection and pulmonary embolism. It can also be helpful to rule out oesophageal perforation. Endoscopy may be unnecessary when the clinical picture and radiological findings are characteristic of an oesophageal haematoma. Nonetheless, endoscopy is likely to be the first major diagnostic intervention in light of the clinical manifestations of these patients (Geller and Gostout, 1998). The haematoma is visible as a purplish lesion with smooth normal overlying mucosa (Vyas et al, 2004). The endoscopic find-

Case Report

A 59-year-old man presented with haematemesis and epigastric pain. He had finished eating a fish meal and felt something 'scrape' the lower end of his gullet. There was no history of preceding retching and he vomited about 100 ml of blood. He had no past medical history and was not on any regular medications. He consumed about 18 units of alcohol per week. On admission he was haemodynamically stable and systemic examination was unremarkable. Initial blood tests revealed normal full blood count, electrolytes, renal function, liver function and clotting profile. He had a gastroscopy (*Figure 1*) which revealed a large bruise and haematoma extending from the arytenoids to the lower end of the oesophagus. There was no sign of any active bleeding. He subsequently had a contrast computed tomography scan of the chest (*Figure 2*) which confirmed para-oesophageal haematoma with no evidence of pneumomediastinum thereby ruling out full thickness oesophageal perforation. He had no further haematemesis while in the hospital and was discharged after observation and conservative management 2 days later.

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ings can be mistaken for a haemorrhagic tumour or a large oesophageal varix (Vyas et al, 2004).

Spontaneous oesophageal haematoma is usually managed conservatively and the prognosis is usually good. Initial management should include the following: nothing by mouth during the acute phase, intravenous fluids, and acid suppression to minimize the risk of ulcer formation.

Conclusions

Oesophageal haematoma should be considered as one of the possible diagnoses in patients who present with retrosternal pain, haematemesis or dysphagia. Awareness of this condition is important as conservative management usually suffices. BJHM

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McGurk C, Rodgers C, Kirby J, Tony C, Tham K (2001) An uncommon but important cause of severe chest pain in an older population. *Age Ageing* **30:** 357

Ouatu-Lascar R, Bharadhwaj G, Triadafilopoulos G (2000) Endoscopic appearance of esophageal hematomas. *World J Gastroenterol* **6**(2): 307–9

Vyas H, Desai D, Abraham P, Joshi A (2004) Heparin therapy for mistaken cardiac diagnosis in boerhave's syndrome. *Indian J Gastroenterol* **23:** 72–3

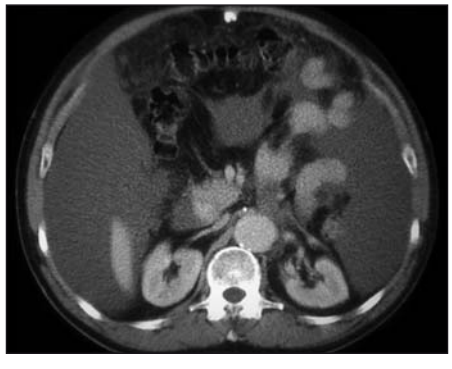
Chyloperitoneum following abdominal aortic aneurysm repair

A 52-year-old man presented with a 3-week history of increasing abdominal distension and lethargy, having undergone repair of a ruptured abdominal aortic aneurysm 12 weeks previously. On examination, there was a healing midline laparotomy scar and the abdomen was grossly distended. Computed tomography revealed the previous aneurysm repair to be intact and demonstrated marked intra-abdominal ascites (*Figure 1*).

Ultrasound-guided insertion of a pigtail catheter (*Figure 2*) yielded 1.8 litres of a milky white ascitic fluid.

The drain was clamped and a sample of the ascitic fluid sent to the laboratory confirmed a markedly elevated triglyceride level consistent with chyle. Chylous ascites is a rare clinical condition resulting from the extravasation of chyle into the peritoneal cavity. It occurs secondary to disruption of abdominal lymphatics by surgery, blunt trauma or malignant neoplastic processes, with abdominal aortic aneurysm repair (Williams et al, 1991; Haug et al, 1998) and retroperitoneal lymph node dissection the surgical procedures most commonly implicated. Conservative approaches to its management are aimed at reducing flow of chyle into lymphatics and include medium-chain triglyceride diets and total parenteral nutrition. Surgical management with peritoneovenous shunts (Sarazin and Sauter, 1986; Boyd et al, 1989) and open ligation of the lymphatic fistula should be reserved for those who have failed conservative treatment (Pabst et al, 1993). BJHM

Figure 1. Computed tomography scan of the abdomen demonstrating marked intraabdominal ascites.



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Boyd WD, McPhail NV, Barber GC (1989) Chylous ascites following abdominal aortic aneurysmectomy: surgical management with a peritoneovenous shunt. *Cardiovasc Surg (Torino)* **30:** 627–9

Haug ES, Saether OD, Odegaard A, Johnsen G, Myhre HO (1998) Chylous complications after abdominal aortic surgery. *Int Angiol* **17:** 244–7

Pabst TS, McIntyre KE Jr, Schilling JD, Hunter GC, Bernhard VM (1993) Management of chyloperitoneum after abdominal aortic aneurysm repair. *Am J Surg* **166:** 194–8, discussion 198–9

Sarazin WG, Sauter KE (1986) Chylous ascites following resection of a ruptured abdominal aneurysm. Treatment with a peritoneovenous shunt. *Arch Surg* **121:** 246–7

Williams RA, Vetto J, Quinones-Baldrich W, Bongard FS, Wilson SE (1991) Chylous ascites following abdominal aortic surgery. *Ann Vasc Surg* **5:** 247–52

Figure 2. a. Ultrasound-guided insertion of pigtail drain yielding (b) milky-white ascitic fluid.