A rare cause of haematemesis and chest pain

Introduction

This article discusses an elderly woman presenting with haematemesis and chest pain who underwent urgent oesophagogastroduodenoscopy. This revealed a large dissecting intramural oesophageal haematoma, initially mistaken for a varix. This is a rare cause of haematemesis and chest pain but has characteristic endoscopic findings. It is a benign condition that may be managed conservatively and both clinicians and endoscopists should be aware of its classical presentation. Misdiagnosis of the chest pain as cardiac ischaemia may have an adverse outcome if antiplatelet or anticoagulation therapy is commenced. Follow up endoscopy a week later showed complete resolution of the lesion leaving a linear mucosal defect.

Discussion

Dissecting intramural oesophageal haematoma is a rare condition classically associated with chest pain, haematemesis and dysphagia or odynophagia, although only 30% of patients present with all three (Cullen and McIntyre, 2000). Chest pain, the solitary symptom in 9% of cases, may be mistaken for acute myocardial infarction with risk to the patient if antithrombotic therapy is commenced (McIntyre et al, 1998). Haematemesis is rarely of significant volume.

While barium studies and cross-sectional radiology may demonstrate the lesion, early oesophagogastroduodenoscopy is considered safe. Indeed a delay may result in a missed diagnosis as the blood dissipates rapidly leaving a longitudinal ulcer (Cullen and McIntyre, 2000). There is often a small tear visible distal to the, usually posterior, haematoma which may provide a clue to the diagnosis.

The condition is benign and patients may be managed conservatively with intravenous fluids and gradual reintroduction of oral diet. Proton pump inhibition is non-evidence-based but may reduce the risk of further ulceration. Prognosis is excellent with complete resolution to be expected within a few weeks.

The patient made an excellent recovery with no further haematemesis. She was discharged with a short course of proton pump inhibition and remained well at clinic follow up. BJHM

Dr Tim Ambrose *is Specialty Registrar in Gastroenterology in the Department of Gastroenterology, Milton Keynes General Hospital, Milton Keynes MK6 5LD,* **Dr Natesan Rajendran** *is Consultant Gastroenterologist in the Department of Gastroenterology, Royal Shrewsbury Hospital, Shrewsbury and* **Dr George Macfaul** *is Consultant Gastroenterologist in the Department of Gastroenterology, Milton Keynes General Hospital, Milton Keynes*

Correspondence to: Dr T Ambrose (tjwambrose@gmail.com)

Figure 1. Endoscopic image of oesophagus demonstrating intramural haematoma.

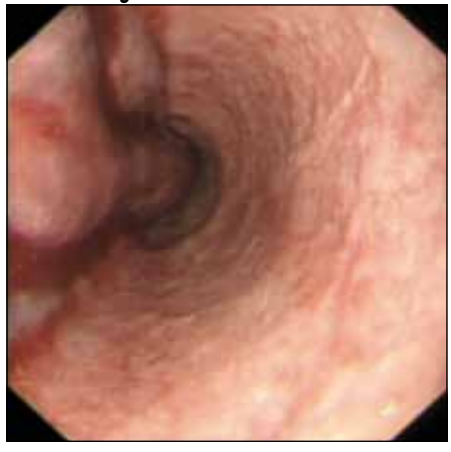
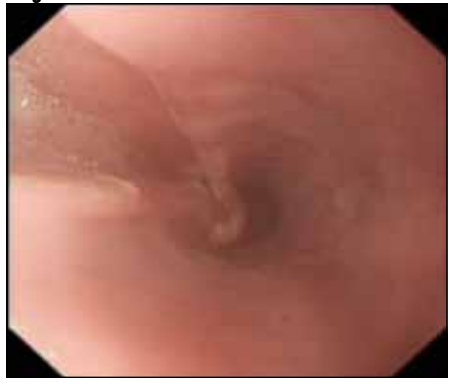


Figure 2. Endoscopic image of oesophagus 1 week later showing resolution of the haematoma and a longitudinal mucosal defect.



Cullen SN, McIntyre AS (2000) Dissecting intramural haematoma of the oesophagus. *Eur J Gastroenterol Hepatol* **12:** 1151–62

McIntyre AS, Ayres R, Atherton J, Spiller RC, Cockel R (1998) Dissecting intramural haematoma of the oesophagus. *Q J Med* **91:** 701–5

LEARNING POINTS

- Clinicians should be alert to the diagnosis of dissecting intramural haematoma of the oesophagus in patients presenting with chest pain and haematemesis.
- Early endoscopy in these patients is safe and delayed endoscopy may miss the diagnosis.
- Prognosis is excellent with complete resolution expected within a few weeks.

Case Report

An 87-year-old retired secretary presented with chest pain and thirty episodes of fresh haematemesis following consumption of a crusty bread roll. She denied melaena or progressive dysphagia. Her weight was steady and appetite good. Her past medical history included mild cardiac failure, hypertension, hypercholesterolaemia, hypothyroidism, and she had undergone hemiarthroplasty for a fractured hip 5 years previously. She consumed negligible alcohol and had not smoked for 25 years, previously with a 20 pack year history. She had never injected drugs, had tattoos or received a blood transfusion.

Her blood pressure was 156/77 mmHg, pulse 122 beats per minute and she was euvolaemic. There were no stigmata of chronic liver disease and her abdomen was soft with mild epigastric tenderness. Rectal examination showed no evidence of melaena. Her haemoglobin was 12.3 g/dl, which did not drop on repeat testing, and urea was 9.4 mmol/litre. All other blood parameters were unremarkable as were chest radiograph and electrocardiogram.

She proceeded to oesophagogastroduodenoscopy (*Figure 1*) which demonstrated a large, purple, linear abnormality extending the length of the oesophagus and protruding into the lumen.

There was concern this was a varix and band ligation was performed. A full screen for liver disease was subsequently normal. Oesophagogastroduodenoscopy was repeated 1 week later which showed a linear mucosal defect (*Figure 2*). The diagnosis was of dissecting intramural oesophageal haematoma.