with three columns of nearly obliterated varices up to 35 cm (Fig) There was a clear area of normal mucosa between the spurting vessel and varices. This was again treated with epinephrine injection. The following day endoscopy showed a vessel in a dimpled area. This was treated with argon plasma coagulation. He received four units of blood (packed RBC), as his hemoglobin level was 7.2 g/dL. He was discharged three days later and has not bled again in the next 2 months.

Approximately 75% to 95% of Dieulafoy lesions are found in the stomach within 6 cm of the gastro-esophageal junction, predominantly on the lesser curve.2 These lesions have been described in the distal esophagus (2% of cases),3,4 duodenal bulb,4 jejunum,4 colon4,5 and rectum.4,5 In our patient the lesion was found in the mid-esophagus, clearly separated from non-bleeding varices below. The association with esophageal varices has not been reported earlier.

References


**Correspondence to:** Dr Abraham, Consulting Gastroenterologist. Fax: (22) 2444 0425

Received March 8, 2004. Accepted June 2, 2004

---

**Dissecting intramural hematoma in esophageal carcinoma**

**Reena George, Ramkumar Govindraj, Sudha Kiran Das, Selvamani Backianathan**

Department of Radiation Therapy Unit II, Christian Medical College, Vellore 632 004, Tamil Nadu

A 50-year-old man with esophageal carcinoma developed severe, refractory, retrosternal chest pain. The diagnosis was made four days later when contrast studies showed an intramural dissecting hematoma of the esophagus. The patient responded to conservative management. [Indian J Gastroenterol 2004;23:221-222]

**Key words:** Esophagus, esophageal dissection

Intramural dissection of the esophagus occurs when a hematoma forms between the mucosal and muscular layers of the wall. It is a rare cause of sudden severe retrosternal chest pain.1

A 50-year-old man on second-line chemotherapy for recurrent esophageal cancer presented with severe retrosternal chest pain, radiating to the back. There was no history of breathlessness or sweating.

A year earlier the patient had been diagnosed to have carcinoma of the lower third of the esophagus and had been treated with chemotherapy and radiation therapy at another center. He was first seen in this hospital when he had a metastatic right supraclavicular node and multifocal recurrence involving the upper and lower thirds of the esophagus. Palliative chemotherapy with docetaxel had been administered two days before the development of the acute chest pain.

The electrocardiogram was normal. The pain worsened over the next few hours despite strong narcotics. Twenty-four hours later the patient also developed low-grade pyrexia. On reassessment it was found that pain was precipitated by swallowing. Examination revealed retrosternal, paraspinal and epi-

**Fig:** Active bleeding from Dieulafoy lesion (arrow) at mid-esophagus before and (below) following successful endoscopic therapy. Esophageal varices seen distal to Dieulafoy lesion (arrowhead)

**Fig:** Esophagogram showing ‘double barrel’ in intramural dissection at D7-D9 level
gastroparesis. There was no subcutaneous emphysema and plain radiographs did not show air in the mediastinum. A gastrograffin swallow demonstrated two vertical collections of contrast in the distal esophagus, separated by a thin radiolucent line indenting the true lumen on the right lateral wall. This ‘double barrel’ appearance was suggestive of intramural esophageal dissection.

The patient was managed conservatively. Oral feeds were withheld and intravenous fluids, antibiotics and analgesics were administered. By the sixth day the odynophagia had reduced and the patient was able to drink fluids. He was discharged a week later. He was readmitted the next month with progressive dysphagia and chest pain of moderate severity. Since the prognosis of the underlying malignancy was poor, extensive investigations were not undertaken. Stenting was not possible as the earlier endoscopy had shown multiple sites of carcinoma including the upper third, lower third and gastro-esophageal junction. A feeding jejunostomy was done and the patient was discharged.

Severe retrosternal chest pain is the cardinal presenting symptom of dissecting intramural hematoma of the esophagus. It is important to distinguish intramural dissection from a cardiac event because anticoagulation will worsen the esophageal hematoma. Symptoms such as dysphagia, odynophagia and hematemesis are present in the majority of cases of intramural dissection. But it may be necessary to ask leading questions to elicit these esophageal symptoms.

Intramural hematomas can be distinguished from transmural perforation by the presence of subcutaneous emphysema in the latter. Emphysema can be easily detected clinically and radiologically when the perforation is in the cervical region. However mediastinal emphysema caused by thoracic perforation is less easy to detect clinically, and may also be missed in chest radiographs done soon after the injury.

Contrast studies can reveal one or more of the following features: a double-barreled esophagus caused by the dissecting hematoma between the mucosal and muscular layers with a radiolucent mucosal strip separating the true and false lumens, or superficial extraluminal spread of barium because of partial-thickness tears of the esophageal wall, or ovoid or elongated submucosal masses projecting into the lumen.

Endoscopy has been safely performed in patients particularly where hematemesis was an early clinical problem. The hematoma is visible as a purplish lesion with smooth normal overlying mucosa. The endoscopic findings can be mistaken for a hemorrhagic tumor or a large esophageal varix.

Factors that predispose to intramural hemorrhage are forceful swallowing of an impacted food bolus, retching, vomiting, bleeding diatheses and anticoagulant therapy. Recurrent intramural dissections have been reported in two patients, both of whom had achalasia cardia. The hematoma in our patient was limited to areas where there was no gross tumor, possibly because submucosal esophageal dissection is less likely where the tumor infiltrates through most of the esophageal wall.

Intramural hematoma has a good prognosis and can be managed conservatively in the majority of cases. Coagulopathies, if present, should be corrected. Oral feeding must be withheld during the acute phase and may be gradually resumed as odynophagia and dysphagia improve. Murata et al reported a case where dysphagia persisted despite several weeks of fasting and IV fluids. Under endoscopic guidance the mucosal bridges were divided using a diathermy knife. This resulted in rapid improvement in symptoms.

References

Correspondence to: Dr George, Associate Professor
Received March 9, 2004. Accepted May 23, 2004

Peritonitis and fulminant sepsis due to spontaneous rupture of ilio-psoas abscess

Sunil Kumar, Sundeep Jain

Department of Surgery, University College of Medical Sciences and Guru Teg Bahadur Hospital, Delhi 110 095

We report a 25-year-old woman who presented with fetaures of peritonitis. At laparotomy, the cause of the pyoperitoneum was found to be a left-sided ilio-psoas abscess. This was drained, but the patient continued to deteriorate with sepsis, and died on the fourth post-operative day. [Indian J Gastroenterol 2004;23:222-223]

Key words: Pyoperitoneum

Ilio-psoas abscess usually presents with a triad of fever, flank pain and limitation of hip movement. We report an patient who presented with peritonitis due to spontaneous rupture of ilio-psoas abscess.

A 25-year-old woman presented with complaints of generalized abdominal pain, abdominal distension and repeated