

Spontaneous Recovery of the Esophageal Obstruction:

Report of 1 Case

Thanya Chetthakul,*

Kesinee Matrakool **

บทคัดย่อ : การอุดตันของหลอดอาหาร รายงานผู้ป่วย 1 รายที่หายได้เอง

โรงพยาบาลมหาสารคาม ได้รายงานผู้ป่วยพระสงฆ์อายุ 72 ปี ซึ่งได้รับการรักษาในโรงพยาบาลเนื่องจากอาเจียนหลังอาหาร 4 วัน อาการเป็นมากขึ้นจนไม่สามารถรับประทานอาหารและน้ำได้เป็นเวลา 2 วัน การตรวจทางรังสีโดยการกลืนแบเรียม พบมีการอุดตันที่หลอดอาหารส่วนต้นและมีการสำลักเอาแบเรียมเข้าไปในหลอดลมส่วนต้น (trachea) และส่วนกลาง (bronchus). ได้ส่องกล้องตรวจทางเดินอาหารส่วนบน (gastroscope) ในวันรุ่งขึ้นและส่องตรวจหลอดลม (laryngoscope) ใน 4 วันต่อมาไม่พบการอุดตัน อาการกลืนลำบากของผู้ป่วยดีขึ้น หลังการตรวจทางรังสีและหายเป็นปกติออกจากโรงพยาบาลได้ใน 10 วัน ได้ตรวจทางรังสี (barium swallowing) ซ้ำ 2 ครั้ง 1 สัปดาห์ และ 4 เดือนต่อมาตามลำดับ พบว่าปกติ คาดว่าการอุดตันและหายเองได้ของหลอดอาหารในผู้ป่วยรายนี้น่าจะเกิดจากอาหารที่รับประทานเข้าไปมากที่สุด

Dysphagia is defined as a sensation of "sticking" or obstruction of the passage of food through the mouth, pharynx or the esophagus. ¹

Classification of dysphagia. ¹⁻³

1. Mechanical dysphagia : dysphagia caused by a large bolus or luminal narrowing from very large food bolus, intrinsic narrowing or extrinsic compression. The common causes include carcinoma, peptic and other benign stricture, and lower esophageal ring.

2. Motor dysphagia : may result from difficulty in initiation a swallow or abnormality in peristalsis and deglutition inhibition due to disease of the esophageal striated or smooth muscle. The common causes are pharyngeal paralysis, cricopharyngeal achalasia, diffuse esophageal spasm and related motor disorder.

Spontaneous recovery of the esophageal obstruction is rare, since 1994 we found 1 case of esophageal obstruction which was cured spontaneously.

* Department of Medicine, Maharat Nakornratchasima Hospital

** Department of Radiology, Maharat Nakornratchasima Hospital

Patient

A 72 year-old Thai monk (HN 88649-37) was admitted on September 6, 1994 because of vomiting after meal for 4 days. About 4 days prior to hospital, he had received large meal, 2 hours later he vomited of ingested food. Since then he had progressive dysphagia of solid and liquid food. He had vomited after meals and could not receive any food or water for 2 days before he was admitted. He was healthy and no history of chronic diseases or weight loss before. Physical examination showed an old monk, looked weak without injection of pharynx, no mass was found.

Laboratory investigations

1. CBC : HGB 12.6 gram/dl, HCT 37.3%, WBC 16700 /cu.mm. MCV 75.8 c u.microns MCH 25.6 pico grams, MCHC 33.8%, neutrophile 80%, lymphocyte 20%.
2. Urine examinations : within normal limits except +1 albumin.
3. FBS 91.3 mg%, BUN 14.87mg%, creatinine 1.67 mg%, Na 141.6 mEq/l, K 3.69 mEq/l, Cl 105.1 mEq/l, CO₂ 17.61 mEq/l
4. Chest x-ray : normal

Progression

The patient was treated with intravenous fluid infusion. The esophagography was performed on September 8, obstruction at upper cervical part of esophagus (fig 1,A) and aspiration of barium into trachea and bronchus (fig 1,2-B) were found ,the varicella and puriform appeared unremarkable ,the lower part could not be evaluated.

After barium swallowing was done, the symptoms of obstruction were improved, he could drink water and some liquid food. The gastroscopy on the next day (September 9), showed whitish mucosa at pharynx, biopsy was performed with normal pathology. Normal esophagus but acute gastritis and duodinitis were seen. The patient was sent to ENT for direct laryngoscopy and found no mass at hypopharynx and larynx, but he had left vocal cord paralysis.

After laryngoscopic examination, symptom of dysphagia was disappear, he could swallow solid food. Repeated barium swallowing on September 20 was normal. (figure 3,4,5,6 He was discharged on the next day and the last time he was seen on January 18, 1995 with in good health, weight gained and normal swallowing function. The third esophagography and chest x-ray were normal

Discussion

Dysphagia with or without chest pain are common presentations of disease of the chest and upper alimentary tract. Chest pain due to pathology of esophagus and stomach is precipitated by deglutition of food and can cause obstruction.

The causes of dysphagia are showed on table 1

Table 1 Causes of dysphagia ^{1,4-9}

Mechanical dysphagia	Motor (neuromuscular) dysphagia
1. Luminal A. Large bolus B. Foreign body 2. Intrinsic narrowing A. Inflammatory condition 1. Stomatitis 2. Pharyngitis, epiglottitis 3. Esophagitis B. Webs and ring 1. Pharyngeal (Plummer-Vinson syndrome) 2. Esophageal (congenital, inflammatory) 3. Lower esophageal mucosal ring (Schatzki ring) C. Benign stricture 1. Peptic 2. Caustic and pill-induced 3. Inflammatory 4. Ischemic 5. Post operative, postirradiation 6. Congenital D. Malignant tumor 1. Primary carcinoma 2. Metastatic carcinoma E. Benign tumor 3. Extrinsic compression A. Cervical spondylitis B. Vertebral osteophytes C. Retropharyngeal abscess and masses D. Enlarge thyroid gland E. Zenker's diverticulum F. Vascular compression G. Posterior mediastinal mass H. Pancreatic tumor, pancreatitis I. Postvagotomy hematoma and fibrosis	1. Difficulty in initiating swallowing reflex A. Oral lesion and paralysis of tongue B. Oropharyngeal anesthesia C. Lack of saliva (e.g. Sjogren's syndrome) D. Lesion of sensory component of N IX, X E. Lesion of swallowing center 2. Disorder of pharyngeal and esophageal striated muscle A. Muscle weakness 1. Lower motor neurone lesion 2. Neuromuscular e.g. myasthenia gravis 3. Muscle disorders B. Simultaneous onset contractions or impair deglutitive inhibition 1. Pharynx and upper esophagus 2. Upper esophageal sphincter 3. Disorder of esophageal smooth muscle A. Paralysis of esophageal body causing weak contraction 1. Scleroderma and related collagen vascular disease 2. Hollow visceral myopathy 3. Myotonic dystrophy 4. Metabolic neuromyopathy (amyloid, alcohol? diabetes?) 5. Aclasia (classical) B. Simultaneous-onset contractions or impaired deglutitive inhibition 1. Esophageal body a. Diffuse esophageal spasm b. Achalasia (vigorous) c. Variants of diffuse esophageal spasm 2. Lower esophageal sphincter a. Disorder of achalasia (1) primary (2) Secondary b. Lower esophageal muscular (contractile) ring

The history can provide a correct presumptive diagnosis in over 80 percent of patients. The type of food causing dysphagia provides useful information. The impacted bolus may be forced through the narrow area by drinking liquid. The report from Canada between December 1984 and September 1991, palliative esophageal intubations were performed in 57 patients. The mean age was 64 years, there were 40 males and 17 females. The more frequent causes of esophageal obstruction were malignant tumors of esophagus (49%), lung (23%), and cardia (19%). Total dysphagia 24.5% and dysphagia to liquid 47% were present in these patients.

This patient had history of progressive dysphagia after large meal 4 days before admitted, complete esophageal obstruction was proved by history of vomiting after solid and liquid food, and by barium swallow radiography (figure 1,2,3). The level of obstruction was at cervical part of esophagus. No evidence of malignancy by gastroscopic and laryngoscopic examination. The most likely cause of esophageal obstruction in this patients was obstructed by food. From this hospital, between 1985 and 1987 Dr. Sunthorn Thaisamak reported of 2 cases of sudden dysphagia due to obstruction by meat ball at the level of middle esophagus seen by barium meal and gastroscopic examination.¹⁰ The foreign body were removed. In this patient we could not see any foreign body, it might be spontaneously relieved after drinking barium meal.

Summary

We reported a case of spontaneous recovery of esophageal obstruction. We cannot demonstrate the cause of obstruction but by history, it might be obstructed by food.

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จาก

บริษัท สมิธแอนดเอนเพฟฟิว จำกัด

344/3 วิทยาลัยการอาชีพบ้านนาโพธิ์ 9 แขวงบางกอกน้อย เขตภาษีเจริญ กรุงเทพมหานคร 10320 โทร. 7196221-7, 7196229 โทรสาร (FAX) 7196220

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