A rare and dangerous cause of dysphagia

M. Gravito-Soares[1,2], E. Gravito-Soares[1,2], P. Souto[1], L. Tomé[1,2]

(1) Department Gastroenterology, Centro Hospitalar e Universitário de Coimbra ; (2) Faculty of Medicine, University of Coimbra, Coimbra, Portugal.

Abstract

The authors present an uncommon case of dysphagia aortica caused by a contained rupture of the descending thoracic aortic aneurysm presenting with dysphagia and atypical retrosternal pain with back radiation successfully treated with endovascular treatment. Although the condition is rare, dysphagia aortica should be suspected in case of dysphagia associated with atypical retrosternal pain or back radiation in a patient with advanced age, short stature and cardiovascular comorbidities. Imaging evaluation should be considered previously to pathology characterization in atypical esophageal ulcers, especially in patients with risk factors for this condition.

Key words : Dysphagia aortica, Esophageal penetrating ulcer, Thoracic aortic aneurysm, and Contained rupture

Question

A 78-year-old woman presented to emergency department with 2 months of dysphagia for solids and retrosternal chest pain with back radiation. The patient's medical history included short stature (155cm), obesity (85Kg ; BMI = 35Kg/m^2), hypertension, dyslipidemia, insulin-treated type-2 diabetes, end-stage renal disease under hemodialysis and second-degree atrioventricular block with pacemaker. Laboratory analysis was relevant for normocytic/normochromic anemia (Hg-11.1g/dL) and C-reactive protein 2.03mg/dL (Normal:<0.5). Esophagogastroduodenoscopy showed an ulcerated lesion bulging in the middle esophagus (Figure 1). Esophageal biopsies showed an unspecific chronic ulceration. Etiological study was negative for infections, autoimmunity conditions or malignancy. Because of no improvement with double-dose proton pump inhibitor and sucralfate 1g q.i.d., a cervical-thoracic computed tomography was done (Figure 2-A,B).

What is the diagnosis and how it should be managed?

Answer

Dysphagia aortica secondary to a penetrating ulcer caused by contained rupture of the descending thoracic aortic aneurysm

Cervical-thoracic computed tomography revealed a circumferential wall thickening with surrounding fat densification without cleavage plane with descending aorta, which had irregular contour and 34mm aneurysmal dilation in the middle esophagus (Figure 2-A,B). An

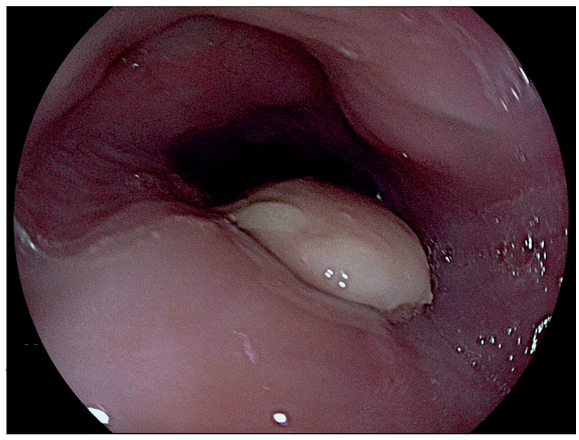

Figure 1. — Esophagogastroduodenoscopy showed an ulcerated lesion bulging in the middle esophagus.

angiography with stent placement was performed, excluding thoracic aortic aneurysm with contained rupture. Additionally, an aneurysm of the right femoral artery was diagnosed and an arteriorraphy was done. The clinical course was uneventful with no recurrence of chest pain or dysphagia. CT-angiography and esophagogastroduodenoscopy of 6-month follow-up showed no leaks or esophageal ulceration.

Dysphagia aortica is an uncommon condition rarely caused by a contained rupture of the aneurysmatic thoracic aorta. Penetrating ulcers into the esophagus or aortoesophageal fistulae are associated with high mortality without treatment. This condition should be suspected in the case of atypical retrosternal pain or back radiation in a patient with advanced age, short stature and cardiovascular comorbidities. This case also underlines the high-risk of taken endoscopic biopsies and the importance of imaging evaluation previously to pathology characterization in atypical esophageal ulcers, especially in patients with risk factors for this condition. We report a rare case of dysphagia aortica caused by a contained rupture of the aneurysmatic thoracic aorta, successfully treated with endovascular treatment.

Correspondence to : Marta Gravito-Soares, Praceta Professor Mota Pinto, Centro Hospitalar e Universitário Coimbra, Gastroenterology, 3000-075 Coimbra, Portugal.
E-mail : ms18498@gmail.com

Submission date : 12/10/2017
Acceptance date : 01/12/2017

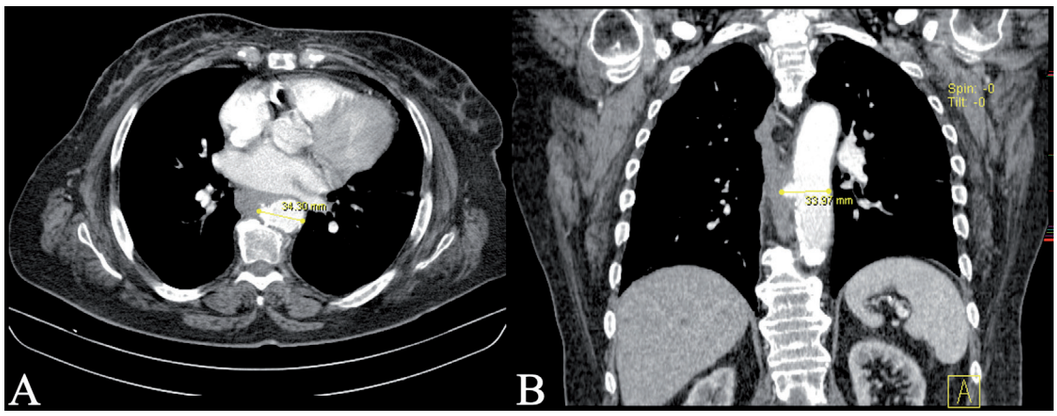

Figure 2. — Cervical-thoracic computed tomography revealed a circumferential wall thickening in the middle esophagus with surrounding fat densification without cleavage plane with the descending aorta, which had irregular contour and 34mm aneurysmal dilation – (A) axial view, (B) coronal view.