Case conference

Supervisor: VS 吳柏衡
Presentor: R1劉邦民
103.06.16

Visit ER at DAY1 04:10

- 48 y/o male
- Chief complaint: 病人主述為非心因性胸痛, 吞嚥困擾
- Triage: 3
- T/P/R:36.6/113/18, BP=128/70, SpO2=100%
- Conscious: E4M6V5

Present illness

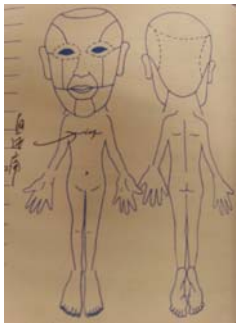
- 睡到一半胸口痛, intermittent, 約 30 秒
- 痛的時候吞東西困難, 現improved
- No SOB/shoulder pain/abdominal pain/head ache/back pain
- Cold sweating(+)
- Cough + sputum for 2-3 months, no fever

Past history

- Allergy: nil
- Medical history:
  - CAD(-), Hypertension(-), DM(+), GU(+)
- Surgical history
  - Lumbar spine OP
- Smoking(+)

Physical examination

- Cons: E4M6V5
- Head & neck: pink conjunctiva
- Chest: clear breath sounds, RHB
- abdomen: soft, no tenderness
- Extremity: no pitting edema

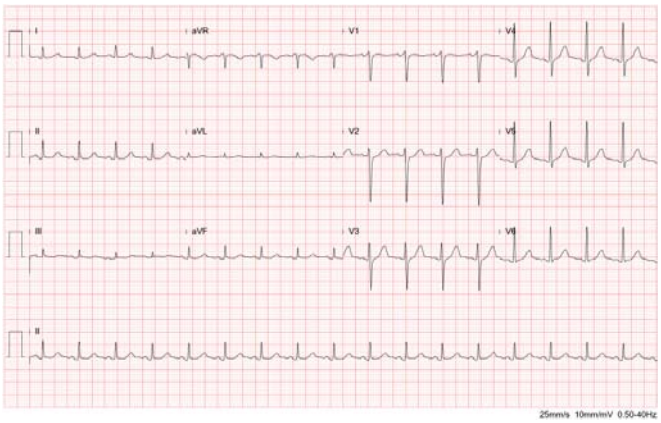


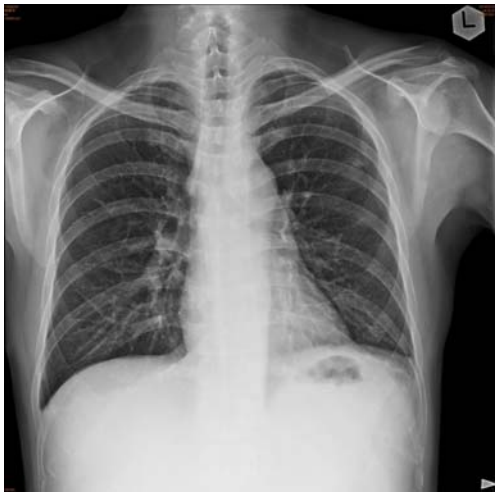
Impression

- Chest pain, must r/o ACS

Management

(0425)
- CXR/ EKG
- CBC/DC/Platelet
- AST, Cr, Na, K, Troponin-I, CK, CK-MB
- PT/PTT
- FS(290)
- N/S 60 ml/hr
- Bokey 3 # PO ST





Laboratory data

CBC/Platelet/DC	**********	
WBC	9.8	x1000/uL
RBC	4.62	10?/uL
Hb	13.9	gm/dl
Ht	40.6	%
MCV	87.9	fl
MCH	30.1	pg
MCHC	34.2	%
RDW	13.3	%
Platelet	185	x1000/uL

Differential count	**********	
Segmented Neutro.	84.3	%
Lymphocyte	4.3	%
Monocyte	11.0	%
Eosinophil	0.3	%
Basophil	0.1	%

GOT(AST)	26	U/L
CPK	23	U/L
Creatinine	0.58	mg/dL
eGFR	149.54	
Na	131	mmol/L
K	4.0	mmol/L
Troponin I	0.03	ug/L
CK-MB	1.0	ng/mL

PT	13.8	second
Normal control	10.4	second
INR	1.31	Ratio
APTT	35.2	second
Normal control	33.4	second
APTT ratio	1.05	

Management / Progress note

0600
- EKG. Troponin-I at 10:30

Progress note: S/S free

0900
- Panendoscopy

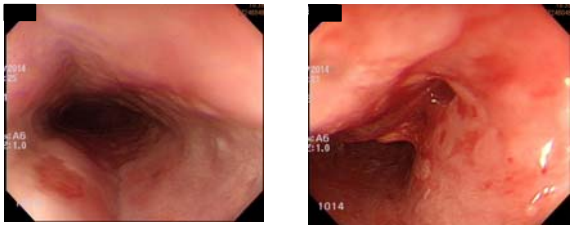
Progress note

-Chest pain for 1 month, ↑after eating & drinking

-Alcohol(+), 已停1 week. Denied previous propulsive vomitus

→ Cannot r/o esophageal lesion, arrange PES

PES finding



- Focal mucosal lesion, r/o fistula, middle esophagus

Management

11:14
•Chest CT with/without contrast

CT scan

Management/ progress note

1407

- Oral contrast CT → (1438) esophagography
- U/A, U/C
- Flumarin 2 g iv st + Q8H IV
- B/C X2
- CRP

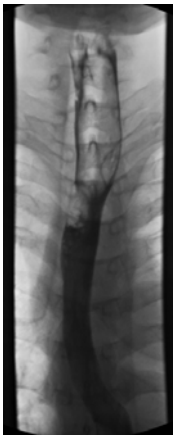
Progress note

-1 weeks sudden on chest pain after eating, 後來有fever

-CT finding:

esophagus: false lumen with debris +/- pseudoaneurysm

left kidney subcapsular fluid, resolving hematoma or infection

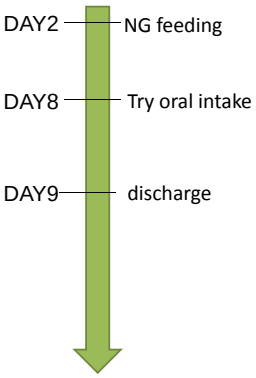


- No evidence of fistula nor extravasation
- Suspect space occuping lesion causing right and anterior deviation of the middle esophagus.

Consult GI/CS doctor

- CS doctor
  - favor esophageal L/W, not favor intramural dissection of esophagus
  - 希GI man 做完PES
- After disscuss between GI & CS doctor →Admission (GI/CS combined care)

Admission course



DISCUSSION

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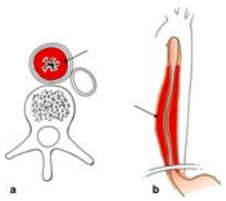
PICTORIAL ESSAY

Intramural hematoma of the esophagus: a pictorial essay

Carlos S. Restrepo · Diego F. Lemos · Daniel Ocazionez · Rogelio Moncada · Carlos R. Gimenez

IHE

- Intramural hematoma of esophagus(IHE)
- Involved submucosal layer
- Most often in the distal esophagus
  - least support by adjacent structure
  - Absence of striated muscle fiber



classification

- abnormal hemostasis
- Emetogenic
- Traumatic
  - iatrogenic, blunt trauma, food induced trauma
- related to aortic disease
- spontaneous

pathogenesis

- Unclear, several theory was proposed
  - Emotogenic: muocsal tear→ hematoma
  - Traumatic
    - Iatrogenic
    - Blunt trauma: rapid changes in the intrathoracic and intraluminal esophageal pressures
  - Abnormal hemostasis
  - related to aortic disease: aortoesophageal fistula
  - spontaneous

Clinical manifestation

Triad (35% 3/3, 50-80% 2/3)

- Chest pain (66–84%)
  - gradual in onset, exacerbates by swallowing
    → intense and severe pain
  - retrosternal or epigastric region
- odynophagia/dysphagia(26–59%)
- Hematemesis : relatively infrequent initial symptom

Image study

- CT scan with iv contrast + oral contrast
- Conventional plain films
  - typically do not reveal any significant abnormality
- Contrast esophagogram
- Endoscopy
  - cannot diagnosis if absence of a mucosal tear
  - further damage concern
- MRI
  - difficulty of evaluating patients with acute chest pain

Treatment

- IHE usually has a benign course and resolve spontaneously within few days (1-3 weeks) with conservative treatment
  - Conservative treatment
    - parenteral nutrition and IV analgesics
    - Antacid
    - Antibiotic (if fever or suspected infection)
- Surgery (if rupture)
- Mortality: 7-9 %
- Transfusion needed : 10%