Intramural esophageal dissection: a rare complication of upper gastrointestinal endoscopy


To the editor

We read with interest the article on intramural esophageal dissection (IED) caused by upper endoscopy by Romano-Munive et al. The author reported that a 21-year-old woman experienced IED caused by upper endoscopy. We also experienced three similar cases in a large tertiary hospital as reported later. Three patients presented with hematemesis on the 5th, 1st, and 10th day, respectively, after gastroscopy. The decline in value of hemoglobin was 40–50 g/l. In Case 1, gastroscopy again revealed a sieve-like opening and mucosal bridge-like changes at min-esophagus with active bleeding, and a CT scan showed double cavity in the upper third of the esophagus. In Case 2, gastroscopy again revealed a mucosal tear and a submucosal hematoma from the upper esophagus to the cardia with longitudinal ulcer, and the Computed Tomography (CT) scan showed a mass lesion in the lower third of the esophagus with proximal dilatation. In Case 3, gastroscopy again showed a hematoma between 25 and 35 cm from incisors with and circumferential dissection of the esophageal mucosa. After about one-half to one month of conservative management they all recovered.

Clinical features are showed in Table 1, and endoscopic appearances are showed in Figure 1.

All these three patients had no history of oral anticoaguants, hematemesis, foreign bodies ingestion, eating burnt or rough food before onset of IED. They all received routine upper Gastrointestinal (GI) endoscopy without any sedation, anesthesia and biopsy. Vomiting stimulated by endoscopy during was suspected to be the cause of IED. The common presented symptoms of IED were chest pain, dysphagia and/or hematemesis. Examinations of endoscopy and radiology were effective for diagnosis of IED. From clinically manifestation, endoscopic changes and conservative treatment, prognosis in three cases of IED induced by endoscopy is good and consistent with those previously reported.

Conflict of interest: None declared.

Table 1. Clinical features of three patients

<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Gender</th>
<th>Time interval between endoscopy and hematemesis (days)</th>
<th>Main manifestation</th>
<th>Transfusion</th>
<th>Lesion healing time</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>78</td>
<td>M</td>
<td>5</td>
<td>Hematemesis, chest pain, dysphagia</td>
<td>Yes</td>
<td>2 weeks</td>
</tr>
<tr>
<td>2</td>
<td>54</td>
<td>M</td>
<td>1</td>
<td>Hematemesis, chest pain, Vomit</td>
<td>No</td>
<td>1 month</td>
</tr>
<tr>
<td>3</td>
<td>61</td>
<td>F</td>
<td>10</td>
<td>Hematemesis, chest pain</td>
<td>Yes</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>
Figure 1. Endoscopic mucosa injury and repair process in different periods of IED.

References