Original Research Paper

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General Medicine

BOERHAAVE'S SYNDROME-AN UNUSUAL COMPLICATION OF SEVERE VOMITING

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ABSTRACT A more extreme version of an esophageal tear that occurs in response to an acute increase in intra-abdominal pressure Boerhaave's syndrome. In this syndrome, a transmural tear with perforation occurs. Like the Mallory-Weiss syndrome, preceding symptoms such as severe vomiting and retching, abdominal straining, blunt trauma, and coughing may precipitate this perforation. The clinical presentation is often catastrophic, with shock and sepsis due to a large esophageal perforation. Because of the acute presentation of severe chest pain, it is often confused with acute cardiac or pulmonary events, dissecting aortic aneurysm, or pancreatitis often leading to a delay in diagnosis and greater morbidity and mortality. Diagnosis is suggested by subcutaneous emphysema with crepitus and radiographic findings of pneumomediastinum and a left pleural effusion or even a frank empyema. Perforation of the esophagus may be confirmed by esophageal contrast studies using Gastrografin. Management is surgical repair and drainage.

KEYWORDS :

CASE STUDY

A 52Year old male is brought in a state of unconsciousness since few hours. On enquiry relatives informed that he had a bout of alcohol with his friends and was later found unconscious in the fields. He was shifted by ambulance services to our hospital.

Pt has tachycardia (rate- 1 16),Tachypnoea (rate -24)and was maintaining saturation with oxygen. Blood Pressure was I00/60 mmHg. Per Abdomen examination -Rigidity present. Chest - Decreased air entry at bases. CVS – unremarkable. CNS- Unconscious, GCS - EIV IM4, pupils B/L NSRL, Plantar -bilateral flexor After a short period of resuscitation patient regained consciousness. He gave the history that he had consumed country liquor and while going to work developed severe bouts of vomiting and subsequently developed chest pain and lost his consciousness. He also complained of severe pain abdomen mostly localized in the epigastrium and also mild substernal chest discomfort associated with nausea. He felt he was feeling better in sitting and on leaning forward. He was complaining of mild cough for the last few months. Attendants complained that the patient was developing swelling on either side of the neck. He was a chronic smoker and alcoholic. On reexamination patient has rigidity and guarding of the upper abdomen , absent bowel sounds . Dullness in the left lumbar region? Spleen / free fluid. CVS and Chest Examination were having same findings. He was maintaining stable vitals. Chest examination revealed equal bilateral air entry with decreased breath sounds at the base. Reexamination few hours later revealed a crunchy sound heard on auscultation. This signified he had a subcutaneous emphysema. The mediastinal crunch in subcutaneous emphysema is called Hamman's sign. The subcutaneous emphysema was gradually progressing.

INVESTIGATIONS

Hemoglobin - 1 2.5gm/dl , total count -9000/microliter ,
ESR-10, PCV -39.7, RBS – 129mg/dl
Urea-29, Creatinine - l.2, Na- 135,
K-4.8
Amylase -77,lipase -65
Total Bilirubin-0.8, SGOT - 24,
SGPT- 24, Alkaline Phosphatase –86,
total protein - 6.4, Albumin-3.1
Viral Markers – Negative.

Chest X ray revealed bilateral air space consolidation and separation of muscle fibers and separation of fat planes -s/o subcutaneous emphysema. An emergency CECT Chest and Abdomen was performed. Extravasation of Contrast from distal part of Esophagus on Left side secondary to ?? Transmural Tear.

Intensely enhancing areas of consolidation with Air Bronchogram in posterior basal segment of both lungs ?? Broncho Alveolar Cell Carcinoma, Moderate Bilateral Pleural effusion ,Left > Right.

Pneumo Mediastinum

Subcutaneous Emphysema

Final Diagnosis

Boerhaave's Syndrome - Trans mural tear of lower esophagus with associated pneumomediastinum (Secondary to forceful retching).

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