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Visual Case Discussion

A case of stomach in the esophagus

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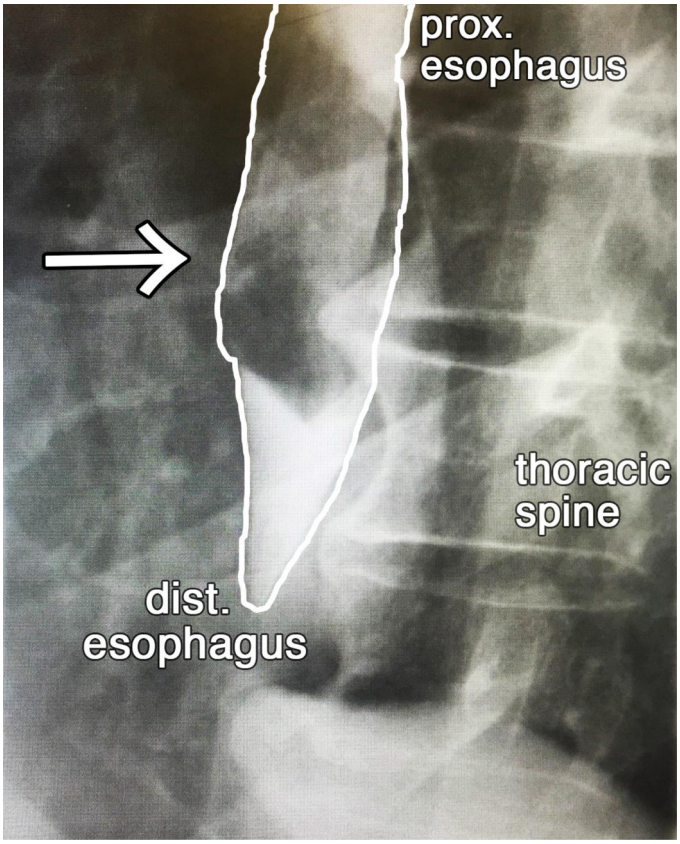
ARTICLE INFO

Food bolus obstruction

A 60-year-old man presented to the ED with a 5 days history of being unable to eat. It started when he ate “sopa de mondongo” (tripe soup) and suddenly began to spit up undigested food. He stated that every time he eats solids, he spits up less than 1 minute later. He had never had symptoms like this before. He denied foreign body sensation, odynophagia, dyspepsia, nausea, abdominal pain, delayed vomiting, chest pain, shortness of breath, or any other symptoms. On physical exam, he was alert and oriented to person, place, and time. He was resting comfortably in bed, talking with family, without wheezing, drooling, or other signs of distress. Not wearing his dentures. Lung exam was negative for stridor or other signs of airway obstruction. The abdomen was soft, non-tender, and non-distended. The patient did not have any neurological deficits on exam that were apparent. Vital signs were within normal limits. He was observed drinking small amounts of liquids without incident. However, 1 minute after taking a few small bites of a sandwich, he regurgitated the solids back up. There was no blood or bile present. An esophagram was ordered.



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Esophagram showing contrast passing through the esophagus (outlined). There is a 4 cm filling defect (arrow) consistent with food bolus obstruction.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.visj.2019.100563.

Questions

1. Which symptom is not typically indicative of a diagnosis of food bolus obstruction?
   a. Chest pain
   b. Sialorrhea
   c. Dyspnea
   d. Odynophagia

2. Which is the preferred treatment of this problem?
   a. Endoscopy
   b. Administration of proteolytic enzyme
   c. Watchful waiting
   d. Glucagon

3. What are some of the underlying causes or concerns that must also be addressed beyond the acute issue?
   a. Previously undiagnosed mass lesions, such as squamous cell or adenocarcinoma
   b. Anatomic causes, such as Schatzki ring, esophageal ring, or diverticula
   c. Dysmotility issues, such as stroke (most common), polymyositis, dermatomyositis, achalasia, diffuse esophageal spasm, ineffective esophageal motility, hypertensive lower esophageal sphincter, or nutcracker esophagus
   d. Eosinophilic esophagitis
   e. All of the above

Answers

1. Dyspnea. Explanation: Squeezing chest pain/neck pain, sialorrhea/drooling, odynophagia/dysphagia, and regurgitation of food are all common symptoms of food bolus obstruction. Dyspnea is indicative of aspiration and is an important clinical distinction. This patient's presentation was unusual in that he was relatively asymptomatic.

2. Endoscopy. Explanation: While glucagon 1-2 mg IV is sometimes given in an attempt to relax the lower esophageal sphincter, this treatment has a low reported success rate. Endoscopy is the treatment of choice for patients who do not respond to expectant management of glucagon administration. The bolus can be removed whole, or in pieces, using a polypectomy snare or Dormia basket. Alternatively, the impacted food may be able to be pushed through to the stomach. Papain, a proteolytic enzyme, is contraindicated due to the risk of mucosal injury or esophageal perforation. Reference: Yoshida C, Peura D: Foreign bodies in the esophagus, in Castell D, Richter JE (eds): The Esophagus. Boston: Little, Brown, 1995:379–394.

3. All of the above. Explanation: While this patient's food bolus obstruction was attributed to swallowing food whole without the use of his dentures, all patients with new onset dysphagia, even after removal of a food bolus, should undergo further GI evaluation to determine the presence of predisposing esophageal pathology.