CASE REPORT

A 76-year-old man was found lay down on the floor. After an acute alcohol intake he started vomiting. In the Emergency Room he was disoriented with lividity. Vital observation revealed low blood pressure and tachycardia, subcutaneous emphysema and basal rales on auscultation. Chest radiography with shadowing in the left lower zone. A water-soluble contrast esophagogram (Gastrograffin) revealed the location and extent of extravasation of contrast material in upper mediastinum (Fig. 1).

With a high degree of clinical suspicion of Boerhaave’s syndrome, it was decided surgical intervention. Prior surgery, we performed an upper endoscopy that showed two ruptures in the esophageal wall with necrosis and dark fluid (Figs. 2 and 3). The patient underwent surgery, during which it was found that there was mediastinitis and three esophageal perforations, two small in the back wall and another of 10 cm long in the side wall of middle third esophagus. Transhiatal esophagectomy with cervical esophagostomy was performed with a favorable evolution.

DISCUSSION

Boerhaave’s syndrome is a spontaneous transmural perforation of the esophagus. It is postulated to be the result of a sudden rise in intraluminal esophageal pressure combined with a negative intrathoracic pressure produced during vomiting.

The classic clinical presentation of Boerhaave’s syndrome usually consists of retrosternal chest and upper abdominal pain and subcutaneous emphysema (crepitation). Odynophagia, tachypnea, dyspnea, cyanosis, fever, and shock develop rapidly thereafter (1,2). The diagnosis is suggested on the clinical history and radiologic images; the chest radiograph and the water-soluble contrast esophagogram (Gastrograffin) are the best for the primary diagnostic study.

Computer tomography scan can reveal decisive criteria for diagnosis and sometimes may replace the esophagrams.
Endoscopy has no role in the diagnosis of spontaneous esophageal perforation, only if we want to exclude other causes of perforation. In our case it was performed immediately before surgery in order to decide the type of surgery to perform.

Surgical repair must be performed as soon as possible. If possible, it is useful to perform an esophagostomy that allows the wound to heal by secondary intention. In severe conditions, like the present patient, it is preferable to perform an esophagectomy (3-5).

REFERENCES