CLINICAL RECORD

CARDIOSPASM.

By J. BOWRING HORGAN, M.B., Ch.B., D.L.O., Cork.

THE patient, a male aged 47, was referred to me in September 1925, suffering from sudden and complete œsophageal obstruction of five days' duration. With the exception of an attack of malaria he had enjoyed perfect health up to the time of his discharge from the Army as an A1 man in 1919, after serving in East Africa for three years. Six months later he had occasional attacks of vomiting when taking food. In February 1924 he began to experience difficulty in swallowing. This necessitated very thorough mastication and the avoidance of all coarse food, in spite of which precautions he had frequent attacks of total inability to swallow which lasted for a day or less. Treatment in two local hospitals having proved ineffectual he was referred to Dublin by his Medical Board. A gastro-enterostomy carried out there failed to effect any improvement; the difficulty and the acute attacks of inability to swallow continued and the patient was becoming seriously emaciated.

The patient's plight was so desperate that I decided upon an immediate œsophageal examination. This was carried out under local anæsthesia in the Mouret position. The walls of the œsophagus were pale but otherwise healthy; there was some fusiform dilatation of the gullet above a central constriction about 37 cm. from the incisor teeth, which I judged to be at the level of the diaphragm rather than at the cardia. Occupying, or rather corking, the centre of the stenosed area was a small mass of what appeared to be green vegetable matter. Upon removing this a circular opening about 3 mm. in diameter was distinctly apparent, the surrounding mucous membrane looking normal. The patient was immediately enabled to swallow fluids and to revert to his habitual restricted dietary.

Some two weeks later, adopting the same method of procedure, I passed a Starck's expanding œsophageal dilator under visual control through a full-sized Brünings' œsophagoscope. I experienced little difficulty in passing through the stenosis the conical gum-elastic end-piece, and eventually the expanding portion of the instrument. The initial effort at mechanical expansion met with considerable resistance. This, however, was suddenly and completely overcome, and I was able to dilate the stenosis, which appeared to be shallow in depth, to almost the full range permitted by the instrument.

The improvement in the patient's condition was magical. He was

https://doi.org/10.1017/S0022215100030486 Published online by Cambridge University Press

able to adopt a normal diet and has continued to do so to date, incidentally increasing two stone in weight.

Starck maintains that errors in diagnosis are common in these cases which are at times confused with angina pectoris, cholelithiasis, spasm, or ulcer of the stomach and pylorus or designated as neurasthenia. He has had five cases on which gastro-enterostomy had been performed in error. He considers that endoscopic instrumental dilatation is preferable to digital dilatation through a gastrostomy, as recommended by von Miculicz and after him by Walton, because it is bloodless, and in expert hands free from risk, and because in many of these cases, more especially in those in which it is not possible to "burst" the constricting muscle fibres, several dilatations (1 to 12) may be requisite. He has successfully treated one patient who was about to submit to a second gastrostomy for digital dilatation.

The closure may be complete, or, as in the above case, simply hypertonic; the temporary acute attacks of disability in this case were doubtless due to a transient corking up of the lumen such as was discovered at the first examination.

The lumen of the stenosed area may be eccentric to the lower end of the fusiform or spindle-shaped dilatation of the gullet which it subtends. Starck, in these cases, employs special endpieces, adapted to the existing condition, which are screwed on to the end of his dilator.

Experience shows that these cases can only be cured by stretching the constricting muscle fibres. Bursting of the sphincteric ring is the necessary precursor of a lasting cure.

REFERENCES.—Starck, Hugo, *Münch. Med. Wochenschrift*, Nr. 11, 1924 (abstract in *Journ. Laryn. and Otol.*, vol. xl., No. 1). Walton, A. J., *British Journal of Surgery*, 1925, vol. xiii.

https://doi.org/10.1017/S0022215100030486 Published online by Cambridge University Press