CLINICAL RECORDS

OESOPHAGEAL CAST

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CORROSIVE burns are not very common in this country. Even more, vomiting of the whole œsophageal cast after HCl swallowing is unknown, although cases have been recorded (œsophagitis dissecans superficialis, which is a benign condition).

The following is an account of a patient who produced a cast following HCl burns.

Case Report

A known depressive patient was admitted to the Psychiatric Block on *6.11.61*, having attempted to swallow HCl (approximately 2 oz.) on *5.11.61*. Mouth burns were not noted but œsophageal pain was present.

On the night of *19.11.61* he retched, producing a cast of his œsophagus which could be seen on indirect examination to come from behind the larynx, which itself was normal.

Œsophagoscopy was performed. The œsophagus was raw and bleeding; the lower end of the œsophagus was detached from the posterior wall. The complete cast itself measures 30 cms. Three small nicks can be seen in the specimen (which is in the Royal College of Surgeons' Museum), these were cut with scissors prior to œsophagoscopy. Fig. 1.

A cervical œsophagostomy was done and a stomach tube passed into the stomach so as to continue feeding through the tube. During his post-operative period the patient developed mediastinal and pleural effusion, which subsided within a week.

Endoscopy on *19.1.62* revealed thin stricture above the level of œsophagostomy, which was dilated. The rest of the œsophagus was ragged and raw, and bled easily on touch. The rubber tube was removed and a smaller stomach tube was passed through the nose and the œsophagostomy opening was allowed to close by itself.

Further endoscopic examinations on *9.2.62* and *9.3.62* showed concentric stricture just above the crico-pharyngeus, wide enough to allow the passage of an adult bronchoscope. The thoracic œsophagus was found to be a narrow rigid tube with only a thin lining of mucous membrane, which stripped easily leaving a bleeding surface. Biopsy of the mucous membrane showed "Chronic inflammation of granulation tissue".

In the intervals between the endoscopies the patient was introducing gum elastic bougies (size 22) so as to keep the stricture in the cervical œsophagus

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open. By this time the patient had put on 7 lbs. in weight, and was discharged home with bougie.

PAST HISTORY

August, 1953	Perforated D.U.—repaired; uneventful recovery.
November, 1955	Partial gastrectomy. Developed regurgitation of bile.
July, 1956	A "Pantaloons" operation for regurgitations of bile and no further complication.
May, 1960	Admission to Neurological Unit for migraine.
July, 1961	Re-admitted to Neurological Unit for severe headache—Ligation of left sup. temporal artery.
August, 1961	Third admission for migraine and depression, this was followed by swallowing of acid.

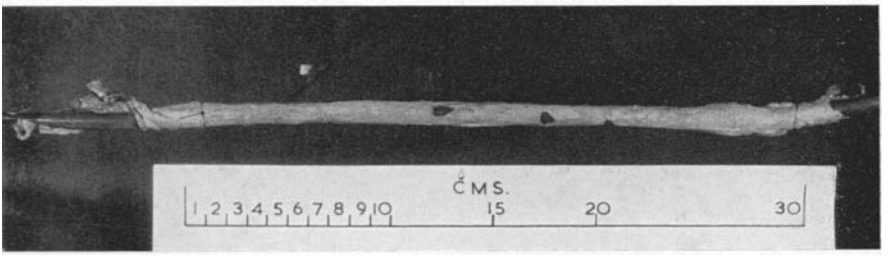


FIG. 1.

The patient reported back in *April, 1962* with difficulty in swallowing and severe depression, for which the Psychiatrist was consulted, and it was decided to subject him for œsophagectomy and plastic repair. He was transferred to St. James's Hospital, Balham where the following were carried out.

Jejunostomy was performed on *12.6.62* to improve nutrition. This leaked and so revision of jejunostomy and drainage of sub-phrenic abscess were carried out on *17.6.62*. Thereafter his general condition improved although his depression was worse.

Bouginage was carried out up to size 22, and this size went through with very little difficulty. Although œsophagoscopy showed a stricture at 15 cms., large bougies could be passed through it easily. In view of this fact it was thought that part of his dysphagia could be due to biliary reflux up the œsophagus due to his previous gastrectomy. Accordingly a Roux conversion of gastrectomy was carried out on *19.7.62*. Definite improvement followed soon after operation and the patient was able to start taking small quantities of solid food relatively easily.

Unfortunately, the patient collapsed on *24.7.62* and died within an hour.

Post-mortem revealed:

Bilateral bronchopneumonia.

Œsophagus was narrowed and markedly thickened, particularly at the junction of middle and lower third.

Summary

An unusual case of œsophageal cast is described here.

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