Emergency presentation of oesophageal carcinoma. An unusual case

T Al-Janabi, R Brown

A 48 year old woman was brought by ambulance to the department with a history of shortness of breath of five days duration.

Examination revealed a normotensive, tachypneic, tachycardic, afebrile woman who was in obvious respiratory distress with an audible wheeze. Her saturation was 91% on five litres of oxygen by mask on admission. Her chest examination showed bilateral basal crepitations and few expiratory crepitations in the right lung field. She received a single dose of frusemide, based on a working diagnosis of acute left ventricular failure. Her ECG showed sinus tachycardia and her chest radiograph showed a widened superior mediastinum (fig 1). Her blood gases showed a low hydrogen ion concentration, low PaCO_2 , low PaO_2 with normal bicarbonate. A diagnosis of pulmonary embolism was considered and intravenous heparin was started. Within the next 15 minutes, she decreased her saturation further to 83% and finally to 61%. Despite undergoing a rapid sequence induction and endotracheal

Figure 2 Spiral chest computed tomogram showing an oesophageal carcinoma invading the left main bronchus with left lung collapse.

intubation, it was difficult to maintain her saturation above 85%. Urgent spiral chest computed tomography, to rule out a pulmonary embolus, showed a large mass posterior to the trachea arising from an invasive oesophageal carcinoma. The left main bronchus was narrowed to a slit with left lung collapse with compensatory hyperinflation of the right lung (fig 2).

The most common presentation of oesophageal carcinoma is progressive dysphagia.¹ However, a host of other presentations have been mentioned in the literature, none the same as the one mentioned here. Fistulas to other nearby organs have been described with an emergency presentation.²⁻⁴ Emergency physicians need to be aware of such a presentation. However, a careful ruling out of the more common causes needs to be undertaken first.

Figure 1 Chest radiograph showing widened mediastinum.

Department of
Accident and
Emergency, King's
College Hospital,
Denmark Hill, London
SE5 9RS, UK

Correspondence to:
Mr Al-Janabi, Specialist
Registrar in Accident and
Emergency
(tarik.al-janabi@kcl.ac.uk)

- 1 Schwartz S, Shires G, Spencer F. *Principles of surgery*. 5th ed. Singapore: McGraw Hill, 1989.
- 2 García de Lucas MD, Ramírez Ortiz LM, Pinel Julian LM, et al. An aorto-oesophageal fistula as the initial manifestation of oesophageal carcinoma. *Gastroenterol Hepatol* 1999;22:320-1.
- 3 Avis SP. Esophageopericardial fistula. An unusual cause of sudden unexpected death. *Am J Forensic Med Pathol* 1999;17:83-5.
- 4 Kohl O, Schaffer R, Doppl W. Purulent pericarditis as an initial manifestation of esophageal carcinoma. *Dtsch Med Wochenschr* 1999;124:381-5.