Emergency presentation of oesophageal carcinoma. An unusual case

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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 PaCO2, low PaO2 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 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. 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. 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.