



Causes and Management of Esophageal Hematoma: A Review

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This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Review Article

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ABSTRACT

Intramural hematoma of the esophagus (IHE) or dissecting intramural hematoma is a relatively unusual complication of acute mucosal and submucosal lesions that results in a blood accumulation between the layers of the esophagus. Esophageal hematoma is a rare condition that

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can develop spontaneously or as a result of trauma, poisoning, or medical intervention. Mallory-Weiss syndrome, Boerhaave syndrome, and IHE are all forms of acute mucosal damage of the esophagus, with IHE being the rarest of the three. In general, esophageal traumatic damage, including traumatic penetration and perforation, is uncommon, making IHE incidence and prevalence difficult to measure. Although most esophageal hematomas are asymptomatic, they can cause significant chest discomfort, dysphagia, and hematemesis. Esophageal hematomas should be distinguished from Mallory-Weiss tear and Boerhaave's syndrome, which they may closely resemble in such cases. Moreover, cardiovascular and respiratory diseases should be ruled out, therefore further tests such as an electrocardiogram, chest X-ray, and laboratory testing can be useful. The majority of cases resolve with conservative treatments, with symptoms disappearing in 1-2 weeks. NPO, IV fluids, acid suppression, and treatment of coagulopathy are all conservative procedures. This review aims to summarize current evidence on etiology, epidemiology, diagnosis and management of esophageal hematoma.

Keywords: Esophageal hematoma; anticoagulation; treatment & management; spontaneously.

1. INTRODUCTION

Esophageal hematoma is a rare condition that can develop spontaneously or as a result of trauma, poisoning, or medical intervention. Marks and Keet described a case of spontaneous intramural esophageal hematoma in 1968. This unusual illness is now well-documented in the scientific literature [1–7]. The oesophagus is a muscular tube that links the throat to the stomach and is around 25 centimetres long. It is made up of four layers: the innermost mucosal layer, the submucosal layer, the muscle layer, and the adventitial layer. The submucosal layer is the layer underneath the mucosa. Blood arteries, the Meissner nerve plexus, and esophageal glands are all found in the second layer of submucosa, which links the mucosal and muscular layers. Intramural hematoma of the oesophagus (IHE), or dissecting intramural hematoma, is a relatively unusual complication of acute mucosal and submucosal lesions that results in blood accumulation between the layers of the esophagus. IHE can occur spontaneously or as a result of trauma involving a foreign body, toxic drug consumption, or iatrogenic intervention. Symptoms of IHE might be similar to those of other acute cardiopulmonary disorders. Acute chest discomfort, odynophagia or dysphagia, and hematemesis are the classic trio associated with IHE [8-11].

The two types of IHE are traumatic IHE and spontaneous IHE. The vast majority of esophageal instrumentation, such as endoscopic procedures or biopsies, causes traumatic IHEs. Spontaneous causes include increased intra-abdominal pressure caused by vomiting, coagulation issues, and renal failure. Antiplatelet therapy has also been linked to an increased risk

of IHE. IHE symptoms include acute retrosternal pain, odynophagia or dysphagia, hematemesis, and heartburn, with the clinical triad of acute retrosternal pain, odynophagia or dysphagia, and hematemesis being the most common. Only 35% of IHE patients have all three of these symptoms, while 95% have at least one. Hematemesis is usually less severe than in Mallory-Weiss syndrome patients [9,12-17].

Esophageal hematoma is a possible cause of acute chest discomfort that is likely to become more prevalent as the use of various antithrombotic drugs increases. Unless further symptoms motivate endoscopic investigation, early diagnosis might be difficult and relies on proper imaging techniques, such as computed tomography. If an endoscopy reveals a big solitary hematoma, an aorto-esophageal fistula should be ruled out radiologically. Because spontaneous luminal rupture followed by easy mucosal repair is typical, conservative treatment is usually suitable after the diagnosis is established [18].

2. ETIOLOGY

Esophageal hematomas are most usually associated with vomiting or retching, but spontaneous hematomas (which occur more frequently in individuals with bleeding problems) can also occur.

Coagulopathies (such as haemophilia or treatment with anticoagulants or aspirin) are a group of instruments that cause or predispose to esophageal hematoma (such as with endoscopy or variceal sclerotherapy), Consumption of a foreign body Food-induced damage, chest trauma (due to abrasive trauma caused by

foodstuffs), cardioversion and anticoagulation, toxicity ingestion, and endotracheal intubation are all factors to consider [1].

The blind insertion of a transesophageal endosonographic probe for valvular heart disease detection, as well as its growing use during cardiothoracic surgery, increases the risk of esophageal hematoma development. According to a recent assessment of the literature on the relationship between transesophageal echocardiography and gastrointestinal bleeding after cardiac surgery, the total proportion of postoperative gastrointestinal symptoms was 11%, and frank upper gastrointestinal haemorrhage was 2.1%. Only two patients suffered bleeding issues during a multicenter study of 10419 tests on the safety of transesophageal echocardiography, necessitating cessation of the procedure. To reduce contact pressure and esophageal mucosal injury, most authors propose a careful examination of upper digestive symptoms to rule out underlying esophageal disease, adequate lubrication of the endosonographic tip, and avoiding fixing the probe in a flexed posture for lengthy durations [19].

Spontaneous Intramural Oesophageal Haematoma is frequently linked to coagulopathies or the use of antiplatelet or anticoagulant medications. This was clear in one case study in which the patient had been on clopidogrel for a long time. She also had uncontrolled hypertension, which, while not typically mentioned as a contributory factor, is included in a number of case reports as part of the previous medical history. Given that the patient had been complaining of chest discomfort for three weeks before presentation, the haematoma may have developed gradually, probably as a result of a minor capillary leak aggravated by uncontrolled hypertension and antiplatelet medication. Coagulopathies and anticoagulant therapy are the key underlying reasons, and care is generally conservative, as documented for spontaneous haematomas in other regions of the gastrointestinal system [20].

The oesophagus can be injured anywhere along its length. Surgical repair of abdominal perforations is the primary method. Non-operative primary care is suitable for many thoracic and cervical perforations, with surgery as a second-line treatment option. The method used is typically determined by the patient's clinical condition and the existence (or absence)

of damage to neighbouring anatomic structures. The trachea is on one side, the spine is on the other, and the carotid sheath is on both sides of the cervical esophagus. Penetrating damage to the cervical oesophagus is intimately linked to injury to neighbouring critical tissues in terms of morbidity and death. The cervical esophagus, along with the region delimited by the inferior pharyngeal constrictor and the cricopharyngeus muscle, is the most at-risk zone for iatrogenic instrumentation damage in the normal esophagus [21].

3. PREVALENCE

In general, esophageal traumatic damage, including traumatic penetration and perforation, is uncommon, making IHE incidence and prevalence difficult to measure. In one major case series study, the first peak was around 45 years old, and the second peak was at 75 years old. For unexplained reasons, IHE has been seen more frequently in older women, who are twice as likely to acquire the disorder as males. Despite the fact that the emergence of this entity is an uncommon event, with the simple availability of contemporary radiological and endoscopic equipment, it is increasingly being detected early [8,22–24].

The usual incidence of EI may be as low as one to two instances per month, even in big trauma centres. Gunshot wounds (approximately 75%) and stab wounds (approximately 15%) are the most common etiologies of penetrating injuries in the United States. Many penetrating EIs have been linked to injury to adjacent structures, including mediastinal organs. Combined esophageal and tracheal perforations, albeit unusual, can be fatal. If the great vessels were also damaged, the mortality rate would be exceedingly significant. Penetrating damage to the esophageal hiatus may result in injury to other vital organs and tissues [21].

4. DIAGNOSIS

In the literature, IEHs have been labelled as esophageal apoplexy, intramural haemorrhage, and intramural dissection. It can happen after an oesophagus dilatation operation. Chest discomfort and/or hematemesis are the most common presenting symptoms. In 35% of people, the triad of chest discomfort, dysphagia, and hematemesis is present. Epigastric discomfort and odynophagia are two more possible symptoms. Due to the generic nature of

the symptoms and the rarity of SIEH, other cardiovascular and gastrointestinal disorders are frequently examined before a diagnosis is made. Endoscopic observations of a longitudinal vascular lesion or a mass lesion with luminal compression may also indicate the presence of esophageal varices or cancer. An intraluminal or intramural soft tissue density can be detected with a CT scan. Upper gastrointestinal endoscopy is the preferred examination, which frequently reveals a friable mucosa with a blue longitudinal hematoma, with or without signs of mucosal break. The use of endoscopic ultrasonography to make a diagnosis may also be beneficial [25-31].

Esophageal lesions such as Boerhaave or Mallory-Weiss syndrome are among the clinical differential diagnoses for intramural hematoma of the esophagus. Boerhaave syndrome is a complete transmural rupture of the distal oesophagus caused by a rapid increase in intraesophageal pressure, which can occur as a result of violent vomiting, severe coughing, abrupt trauma, childbirth, straining, or weight lifting. Mackler's triad is a typical clinical presentation that includes vomiting, lower thoracic discomfort, and subcutaneous emphysema. The oesophagus is torn and ruptured at the bottom portion of the esophagus. Following a strong cough, retching, or forceful vomiting, Mallory-Weiss syndrome causes a longitudinal mucosal rupture at the gastroesophageal junction or stomach cardia. Hematemesis is the most common symptom. Other digestive pathologies such as perforated peptic ulcer and pancreatitis, cardiac or vascular diseases such as ischemic heart disease, dissection or aneurysm rupture of the thoracic aorta or pulmonary embolism, or pulmonary lesions such as pneumothorax can all be misdiagnosed as intramural hematoma of the esophagus [32-36].

The diagnosis is usually made with a barium swallow or a CAT scan, which shows intraluminal filling deficiencies or a double-barrelled appearance of the esophagus. Endoscopy has been the primary examination in recent years, especially when hematemesis is the presenting symptom [37-43].

To rule out cardiovascular and respiratory diseases, further tests such as an electrocardiogram, chest X-ray, and laboratory testing are useful. Historically, barium or gastrografin swallows were used to detect an intramural esophageal hematoma. Chest CT or

MRI scans, upper gastrointestinal endoscopy, and endoscopic ultrasonography are all common procedures nowadays. Historically, the predominant radiological imaging was barium or gastrografin swallow, which showed an extended tubular filling defect with smooth edges or a stripe of contrast filling the dissection area as well as the esophageal lumen (mucosal stripe sign or double-barreled esophagus). The initial quick and noninvasive radiological study of choice is currently a chest CT scan, which can rule out various thoracic diseases. The esophageal wall thickening is generally symmetric or asymmetric, with a well-defined non-enhancing, high-attenuation intramural esophageal mass running down the esophagus wall [33]

5. MANAGEMENT

The majority of cases resolve with conservative treatments, with symptoms disappearing in 1-2 weeks. NPO, IV fluids, acid suppression, and treatment of coagulopathy, if present, are all conservative procedures. In stable individuals, a soft diet can be initiated and progressed based on symptom improvement. Surgical intervention is normally reserved for patients who have had a major haemorrhage or have become hemodynamically unstable [44].

The following is part of medical care management: [1]

- For the first several days, nothing by mouth (NPO) should be applied. Oral intake should be progressively resumed. On days 4-6, a stable patient can begin a soft diet. Most patients are able to swallow within a few days, thus parenteral nutrition is rarely necessary.
- While the patient is NPO, intravenous fluids and a blood transfusion should be given if necessary. To lessen the risk of esophageal ulcers, acid suppression should also be addressed. As needed, antiemetics are prescribed.
- Any coagulation abnormalities should be addressed.
- Sclerosant injections have been used to treat large esophageal hematomas on occasion. Because this condition is so uncommon, a clear indication for its treatment has yet to be established. The rupture of the intramural hematoma is a common complication of endoscopic sclerotherapy [1].

Because spontaneous remission is the norm, esophageal hematomas are treated conservatively with a nil-by-mouth diet, intravenous alimentation, and antibiotics in severe instances. Surgery to remove a hematoma and close an esophageal mucosal rupture is only done in rare cases [39]. Recurrent bleeding or difficulties should raise suspicion of hematoma leakage or rupture into the esophageal lumen, as well as an enlarging hematoma, and should be treated as an urgent emergency with airway protection and hemodynamic resuscitation. In the case of recurrent major hematemesis, therapeutic angiography may be required to control bleeding and hematoma growth caused by transarterial embolization. Surgery is typically linked with poor results, although it may be essential if conservative therapy fails or if a patient has large recurrent bleeding resulting in hemodynamic instability or severe esophageal luminal blockage or perforation [8].

6. CONCLUSION

Esophageal hematoma is an uncommon disorder that can occur spontaneously or as a result of trauma, poisoning, or medical intervention. Being rare it can often be misdiagnosed. Therefore, careful approach to the diagnosis should be followed. Some test such as CT, and x-rays can be used to rule out any cardiovascular or respiratory diseases. Endoscopy can be used for diagnosis; however it may also increase the risk of bleeding. The majority of cases resolve with conservative treatments, with symptoms disappearing in 1-2 weeks. NPO, IV fluids, acid suppression, and treatment of coagulopathy are all conservative procedures.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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