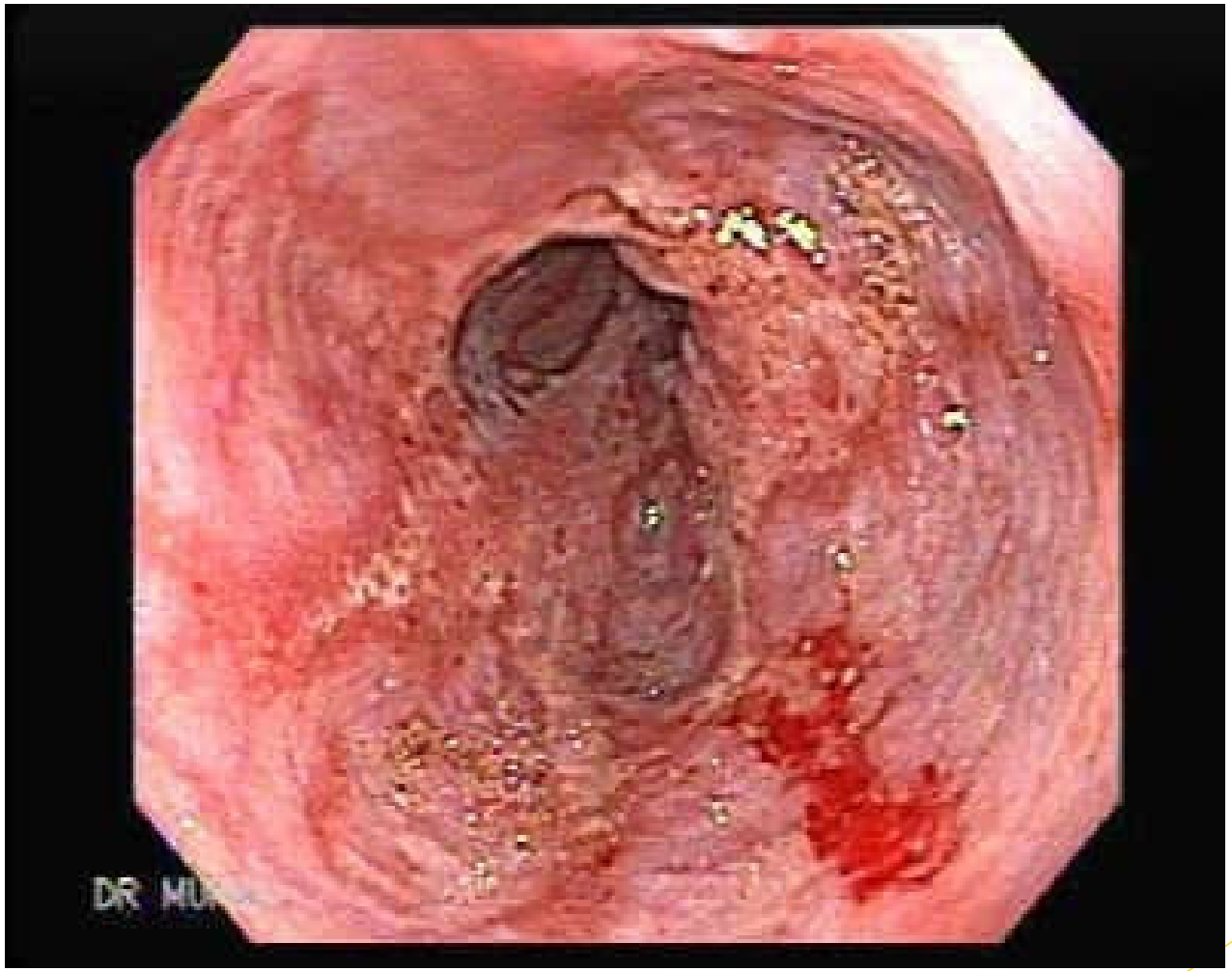
DISORDERS OF OESOPHAGUS

ACUTE OESOPHAGITIS

Acute inflammation of oesophagus due to

1. Ingestion of hot liquid
2. Ingestion of caustic or corrosive agents
3. laceration due to swallowed foreign body or trauma of oesophagoscopy
4. Infection of oesophagus from oral thrush
5. Systemic disorders like pemphigus
6. GERD



Symptoms

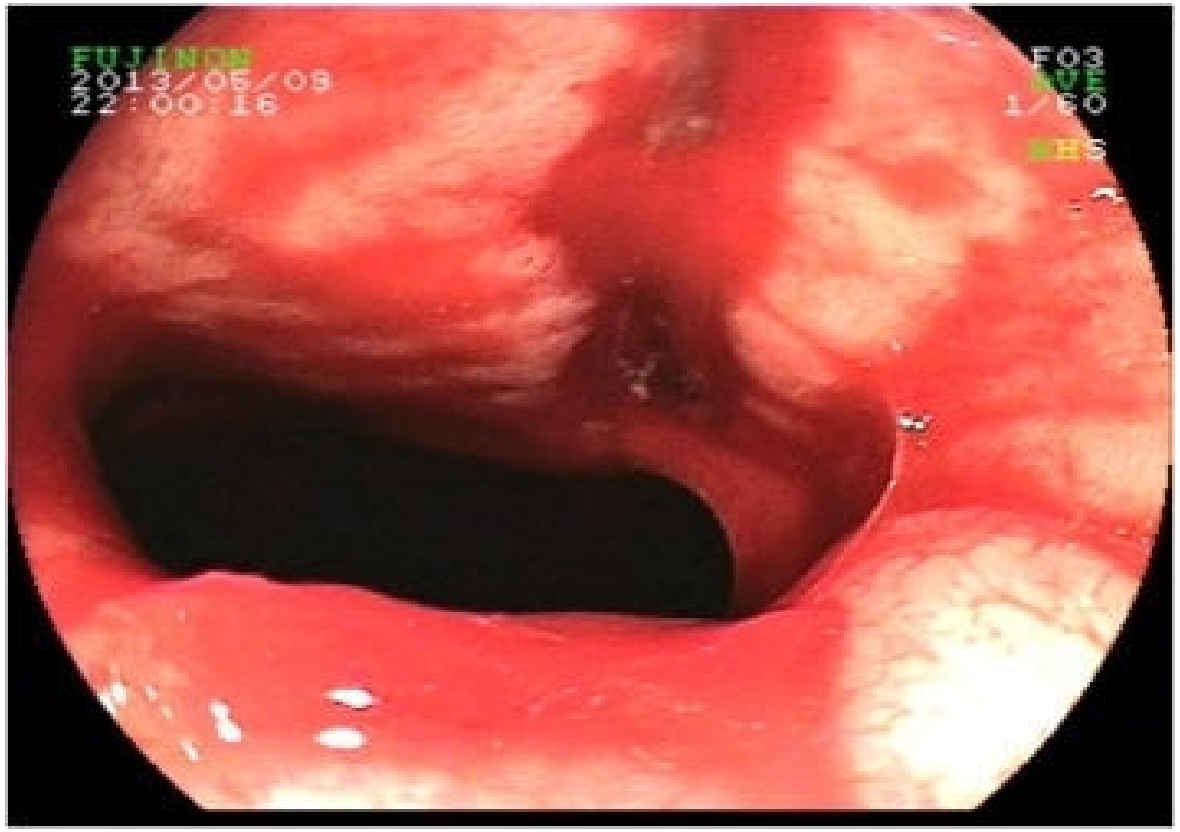
- Dysphagia
- Retrosternal burning
- Hematemesis

Diagnosis

- From history
- X ray study
- oesophagoscopy

Treatment

- Antacids-proton pump inhibitors,H2 receptor blocker
- Steroids



PERFORATION OF OESOPHAGUS

AETIOLOGY

- Instrumental trauma-oesophagoscopy or dilatation of strictures with bougies
- Spontaneous rupture-following vomiting.Involve lower third

BOERHAAVE SYNDROME- post emetic rupture of all layers of oesophagus

DIAGNOSIS

- H/o of pain in the neck or interscapular region ,following an oesophagoscopy
- **Features of cervical oesophageal rupture**

  pain,fever,difficulty to swallow and local tenderness,along with signs of surgical emphysema in the neck
- **Features of thoracic oesophageal rupture**

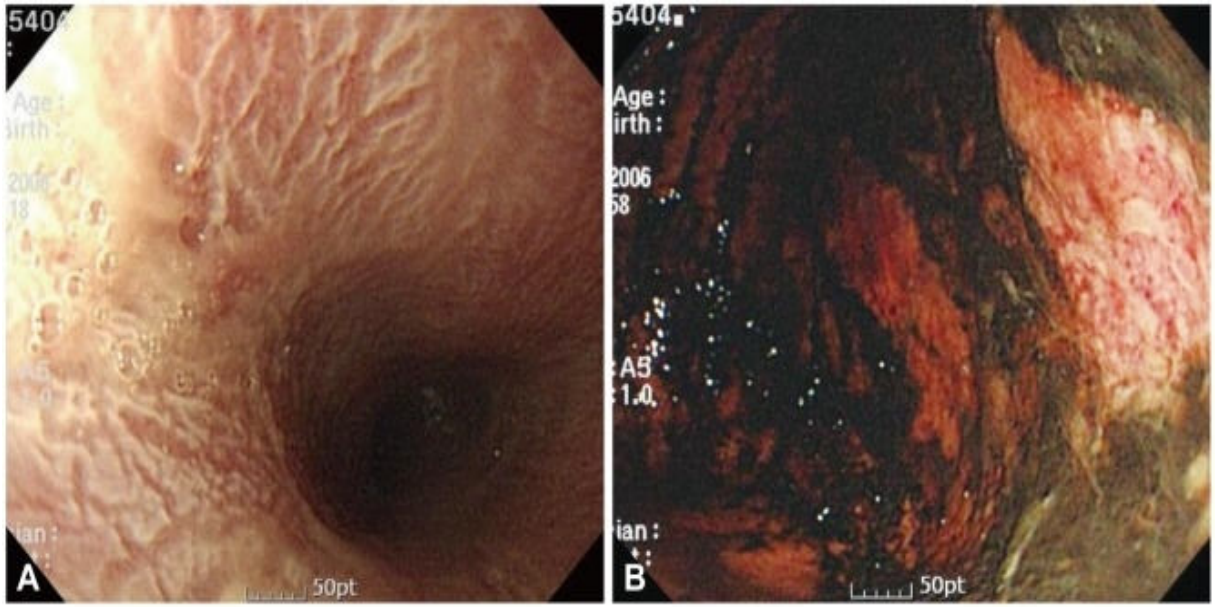
  pain,referred to the interscapular region,fever 102-104 deg F, signs of shock,surgical emphysema in the neck,crunching sound over the heart(**HAMMAN'S SIGN**) and pneumothorax

INVESTIGATION

- X ray chest and neck
- Reveal widening of mediastinum and retrovisceral space, surgical emphysema,pneumothorax,pleural effusion or gas under diaphragm.

TREATMENT

- All oral feeds are stopped immediately
- Nutrition through IV route
- Massive dose of antibiotic given IV
- drainage is required only if suppuration develops
- If diagnosis is made within 6hrs perforation surgically repaired and pleural cavity drained
- If diagnosis is delayed repair is not possible,then drain the infected area



CORROSIVE BURNS OF OESOPHAGUS

AETIOLOGY

- Acid, alkali or chemicals

Accidental swallow by children

Suicidal purpose in adults

PATHOLOGY

Severity is based on

- Nature of corrosive substance
- Its quantity and concentration
- Duration of contact

Alkalies are more destructive and penetrate deep into the layers of oesophagus

- 3 stages of oesophageal burn

1. **Stage of acute necrosis**
2. **Stage of granulations** – slough separates leaving granulating ulcer
3. **Stage of stricture** : begins at 2wks and continues for 2months or longer

Evaluation of patients

- Evaluate and determine type of caustic ingested,signs and symptoms of shock,upper airway obstruction,mediastinitis,peritonitis,acid-base imbalance and associated burns of face,lips,oral cavity

INVESTIGATION

X ray of chest and soft tissue lateral view of neck

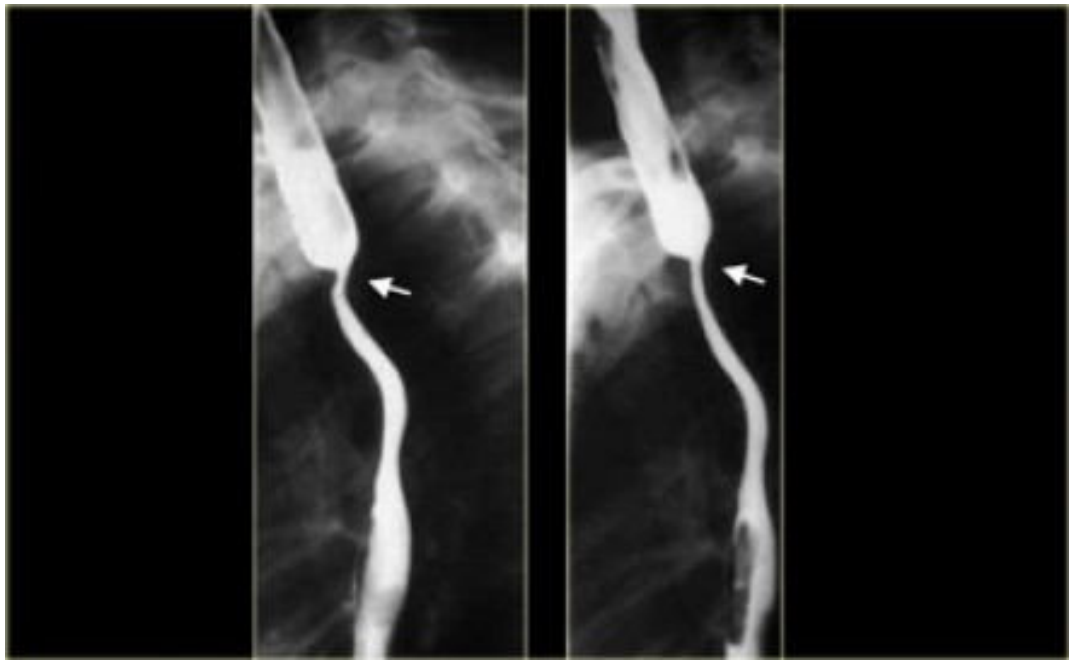
MANAGEMENT

- Hospitalize
- Treat shock and acid-base imbalance
- Relieve pain
- relieve airway obstruction (tracheostomy)
- Neutralization of corrosives (upto 6hrs)
- Parenteral antibiotic
- Pass a nasogastric tube
- Oesophagoscopy

- Steroids (to prevent stricture)
- Follow up with oesophagoscopy every 2wks till healing is complete
- If stricture develops

a. oesophagoscopy and prograde dilatation if permeable
b. Gastrotomy and retrograde dilatation if impermeable
c. Oesophagial reconstruction or bypass if dilatations are impossible

- Corrosive injury may require life long follow up



Benign stricture of oesophagus

AETIOLOGY

- Usually occurs when muscular coat is damaged
- Common causes

1. Corrosive burns
2. Trauma due to impacted FB,instrumentation,injuries
3. Ulceration due to reflux oesophagitis
4. Ulceration due to diphtheria or typhoid
5. Sites of Surgical anastomosis
6. Congenital (lower third)

CLINICAL FEATURES

- Dysphagia
- Regurgitation and cough
- malnourishment

DIAGNOSIS

- Barium swallow
- Oesophagoscopy to exclude malignancy

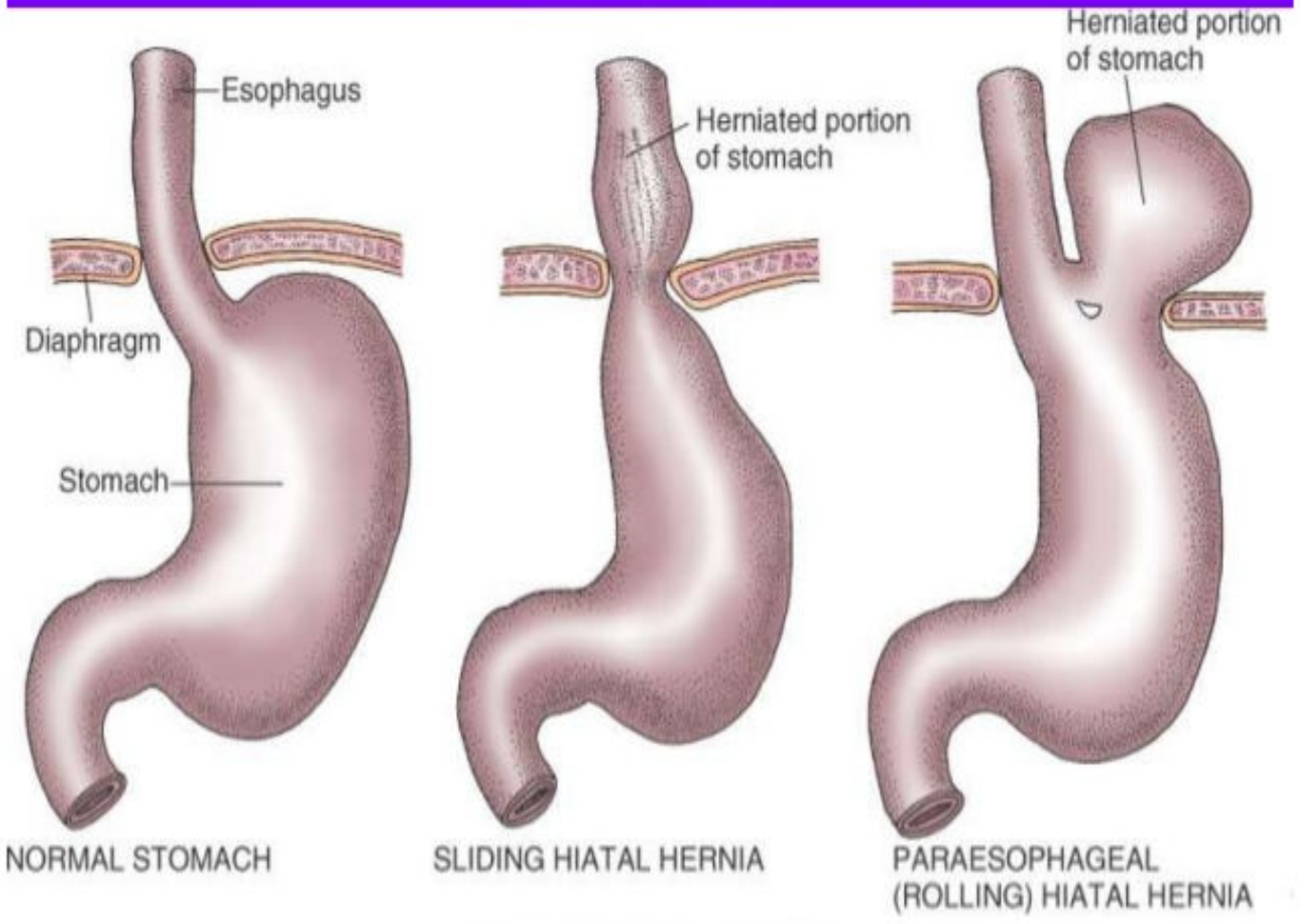
TREATMENT

- Prograde dilatation with bougies
- Gastrostomy
- Surgery-excision of strictured segment and reconstruction of food passage.

HIATUS HERNIA

- DISPLACEMENT OF STOMACH INTO CHEST VIA OESOPHAGIAL OPENING OF DIAPHRAGM
- MOSTLY ELDERLY; PAST 40 YRS
- 2 TYPES
    1. SLIDING
    2. PARAOESOPHAGIAL

HIATUS HERNIA



SLIDING TYPE

Stomach pushed into thorax in line with oesophagus.

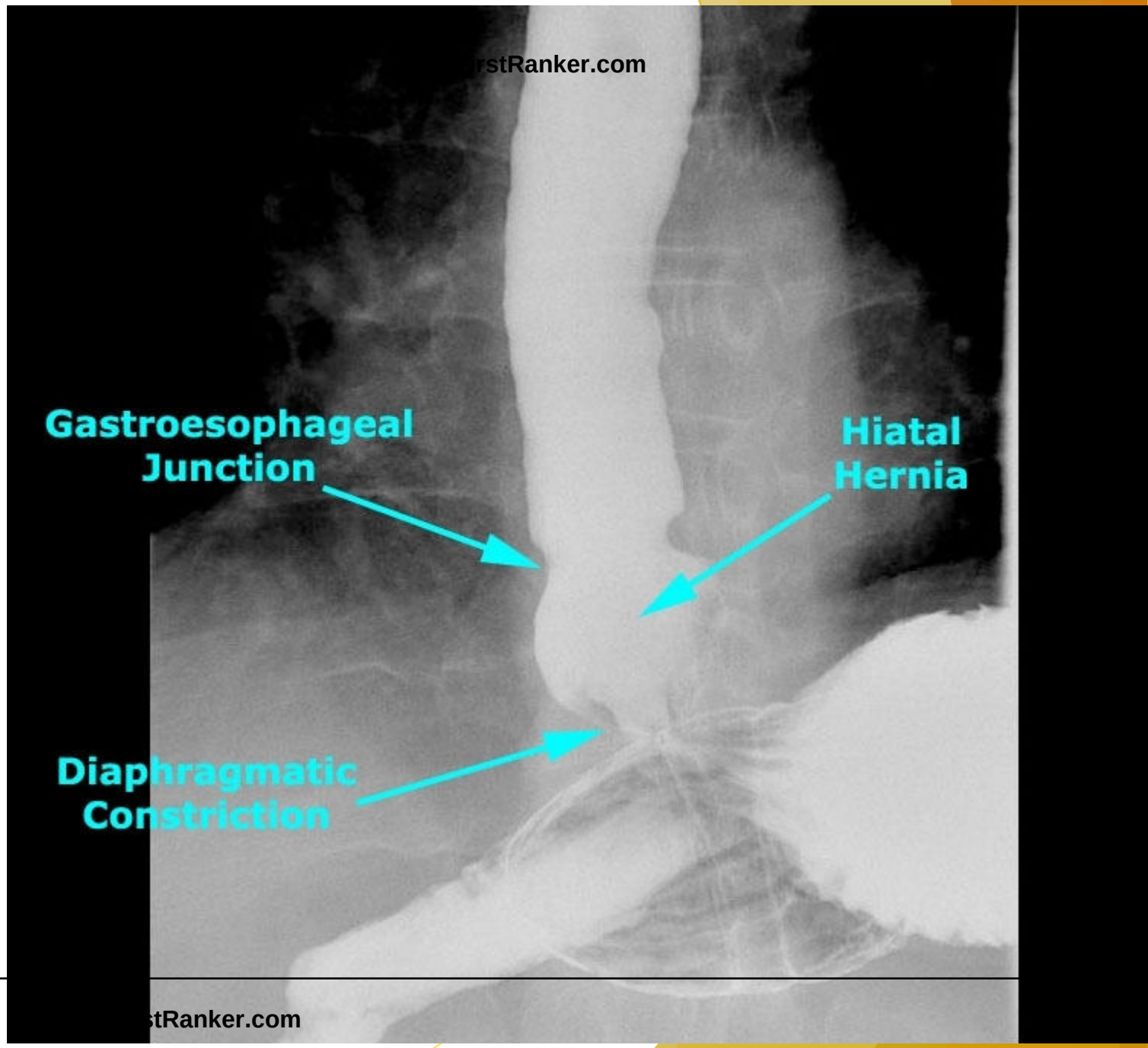
- Reflux oesophagitis is common→ulceration and stenosis
- Haematamesis may occur due to increased intra abdominal pressure

PARAOESOPHAGIAL TYPE

- A PART OF STOMACH AND PERITONEUM PASSES THROUGH THORAX BY THE SIDE OF OESOPHAGUS
- GASTROOESOPHAGEAL JUNCTION REMAINS BELOW DIAPHRAGM AND ANGLE BETWEEN OESOPHAGUS AND STOMACH IS MAINTAINED
- NO REFLUX OESOPHAGITIS
- MAIN SYMPTOMS; DYSPNOEA ON EXERTION AND BLEEDING

DIAGNOSIS

BARIUM SWALLOW



TREATMENT

Surgical - reduction of hernia and diaphragmatic opening repaired

Early cases and cases unfit for surgery→conservatively managed

1. sleeping with head and chest raised
2. avoid smoking
3. antacids and proton pump inhibitors
4. reduce obesity
5. attention to the cause of raised intra abdominal pressure

PLUMMER–VINSON (PATTERSON–BROWN–KELLY) SYNDROME

- Classical features-dysphagia, iron-deficiency anaemia, glossitis, angular stomatitis, koilonychia (spooning of nails) and achlorhydria
- atrophy of the mucous membrane of the alimentary tract
- Affects females more than 40 years of age
- 10%-post cricoid carcinoma

Investigations

- Barium swallow
- Oesophagoscopy
- Shows a Web in postcricoid region

Treatment

- correct anaemia by oral/parenteral iron
- Associated B12 and B6 deficiency should also be corrected.
- Dilatation of the webbed area by oesophageal bougies

Thank you