Dilatation of the Oesophagus Without Organic Obstruction

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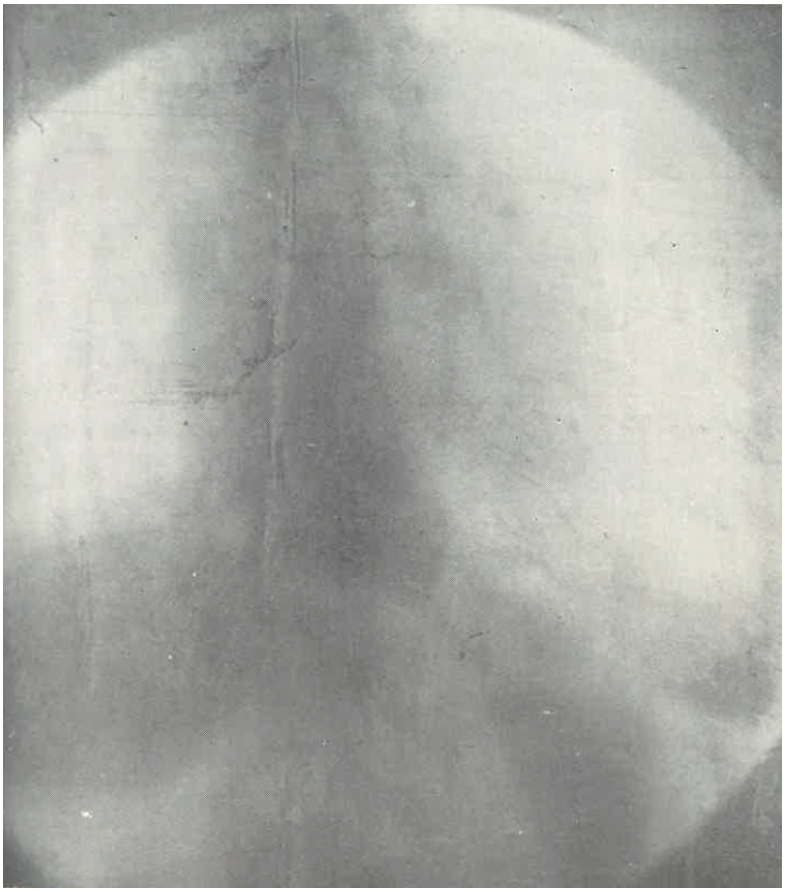

This condition is much more common than is generally supposed, and on that account I am bringing this case under your notice.

The patient is a domestic servant, aged 27. I was called in to see her because of persistent vomiting after meals, and of cough followed by vomiting on lying down, especially at night. The history is that about three years ago she began to have difficulty in swallowing, and regurgitation of food. The condition had gradually become worse, and for the past six months she frequently vomited after meals, and had developed the cough and vomiting on lying down. Lately she had vomited after every meal, and was getting thinner. Thinking the affection was in the throat she consulted Dr. Harty, who had a skiagram of the oesophagus taken. The photograph showed an extensive fusiform dilatation of the oesophagus. I sent her into hospital for further observation and treatment.

She looked fairly well nourished and is not of the neurotic type. Apart from the oesophageal condition we could find no other abnormality. Whilst in bed in hospital and on soft food there was no vomiting, but when put on solid food vomiting returned.

A large sized solid gum-elastic bougie passed down into the stomach meeting with little resistance; a soft rubber stomach tube also appeared to pass into the stomach readily. Another skiagram by Dr. Cameron taken after a bismuth meal showed a similar picture to the previous one. Dr. Harty was good enough to make an oesophagoscopic examination under an anaesthetic. With the patient recumbent and the head hanging over the edge of the table the oesophagoscope was introduced into the oesophagus and immediately evacuated a large amount of food. The oesophagus was examined down to its lowest portion, but it nowhere showed any dilatation or abnormality other than congestion.

It is very evident that the X-rays are essential for diagnosis in these cases.

We are treating this case by daily washing out the stomach and occasionally passing a bougie. Her condition has much improved, but her symptoms occasionally recur and she cannot yet swallow ordinary diet.

I should have mentioned that food regurgitated was alkaline in re-action, but food removed by the stomach tube was acid, showing that the tube actually passed into the stomach.

In Mayo Clinics for 1912, is published a paper by Dr. Plummer entitled "Diffuse Dilatation of the Oesophagus without Anatomic Lesion," and in the Proceedings of the Royal Medical Society for March, of this year, is published a paper with a similar title by Dr. Wm. Hill, and with it is published the discussion which followed.

Dr. Plummer records 91 cases from his clinic, 38 of which he had previously recorded as cases of cardiospasm. He classifies 130 cases of those two conditions thus:—

1. Diffuse dilatation of the oesophagus without anatomic stenosis, 91 cases. No gross lesions were found in this group and only five of the patients were of a neurotic type.
2. Severe cardiospasm without dilatation of the oesophagus—2 cases. Both patients had periodic attacks continuing from 3 to 14 days, during which they were not able to swallow either liquid or solid food.
3. Cardiospasm without diffuse dilatation, but with gross lesions in the stomach—12 cases. Of these cases 2 patients had ulcer, 2 syphilis, 3 carcinoma, and 3 suspected ulcer.
4. Mild cardiospasm without diffuse dilatation or gastric ulcer—24 cases. Almost without exception these patients were of a neurotic type, and many were distinctly hysterical.

Aetiology.—Whether the dilatation of the oesophagus is a primary condition resulting from a paralysis of the oesophageal muscle, or whether it is secondary resulting from a "functional stenosis" of the oesophagus, is a much debated point. Dr. Hill takes the latter view and maintains that the obstruction is not at the cardiac orifice of the stomach, but at the hiatus of the diaphragm, through which the oesophagus passes, and thinks it may be due to a spasm of the diaphragm. The dilatation (oesophagectasia) has been attributed to inco-ordination between the vagus and the sympathetic nerves, and Dr. Shattock has said that it was due to "an inco-ordination of the nervous impulses transmitted by the vagus during deglutition, which impulses should normally cause contraction of the tube above and an active dilatation of the cardia."

In this case that I record, not only did a large gum-elastic bougie pass readily into the stomach, but also did a soft rubber stomach tube. This supports the inco-ordination theory.

It is quite possible that in some cases there is a dilatation without stenosis. Neither sex nor age seems to be a determining factor in the condition. A few cases have been observed in young children.

Symptoms.—These may simulate the results of organic stenosis. Difficulty in swallowing and vomiting immediately after taking food are common symptoms. The conditions may give rise to waterbrash and rumination. In fact this is probably the condition which accounts for many of the reported causes of human ruminants. Loss of weight is not usually marked, but some cases have succumbed to asthenia from starvation. Cough on lying down is a symptom sometimes noted.

Treatment.—Gastrostomy with dilatation of the oesophagus from below has been tried, but sometimes fatally, and is not to be recommended.

Hill follows Plummer in recommending dilatation from above using distensible bags, distended either with water or mercury. Plummer used distension in 91 cases, of which 73 were completely relieved, 4 had died, and 3 were not traced. One died of rupture of the oesophagus due to too high pressure having been used.

Repeated washing out of the oesophagus and stomach and the mere passing of a bougie have been successful in some cases, and are to be recommended in all cases before attempting severer methods. Drugs, apparently, have little curative effects in this condition, nor has much success been achieved by electrical treatment.

Pathology.—Post mortem findings reveal no stenosis and sometimes no thickening of any part of the oesophagus; in some cases the wall of the dilated portion of the oesophagus has been recorded as being a little thinner than normal, but usually it is of normal thickness.

It seems to me that the passing of bougies and the stomach tube has the effect of re-educating the muscles of the oesophagus and restoring co-ordination.

I should like to hear what experience of this condition other members have had.

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