

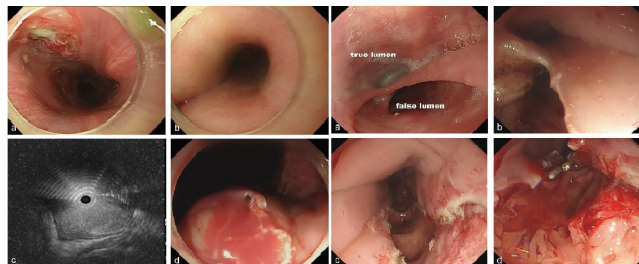
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Endoscopic transection for intramural esophageal dissection caused by a retropharyngeal abscess

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Introduction: Intramural esophageal dissection is rare and characterized by sudden severe retrosternal pain, hematemesis, odynophagia, and dysphagia secondary to longitudinal separation of the submucosa from the esophageal muscularis propria. It is usually precipitated by a rapid increase in intra-esophageal pressure such as intramural hematoma formation. Conservative management usually produces favorable outcomes. **Case report:** A 66-year-old man was admitted with severe pharyngeal pain, dysphagia and dyspnea. Laryngoscopy revealed severe laryngeal edema, and neck computed tomography showed a non-collecting retropharyngeal abscess. He underwent tracheostomy, and despite antibiotic therapy, his fever and chills persisted with worsening dysphagia. Endoscopy showed diffuse swelling between the upper esophagus and the gastric cardia and an upper esophageal opening discharging pus (▶ Fig. 1a,b). Endoscopic ultrasonography revealed that the swelling of the esophagus and the gastric cardia was caused by submucosal pus accumulation (▶ Fig. 1c). Using a needle knife, a mucosal incision was made in the lower esophagus and gastric cardia for pus drainage (▶ Fig. 1d). Esophagography showed esophageal dissection between the upper and lower esophagus with a small amount of leakage from the false lumen of the lower esophagus. Follow-up endoscopy showed a large false lumen (▶ Fig. 2a). Using a hook-knife, the mucosal bridge between the true and false lumens between the upper and lower esophagus approximately 2 cm proximal to the esophagogastric junction was endoscopically transected. Endoscopic clipping was performed for a suspected leakage site (▶ Fig. 2b-d). Oral intake was resumed, and the patient was discharged 2 weeks later after decannulation. Follow-up endoscopy 2 months later showed a single esophageal lumen. The patient was asymptomatic at the 1-year follow-up. **Discussion:** Our patient showed a retropharyngeal abscess that progressed to intramural esophageal dissection and persistent infection and dysphagia despite conservative management; however, he was successfully treated endoscopically.



▶ Figure 1

▶ Figure 2