

Non-operative management of Boerhaave's syndrome

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A 40-year-old man with a history of alcohol abuse and forceful vomiting transferred to our hospital from a district hospital because of dyspnea and fever. A chest X-ray showed bilateral pleural effusion. Chest CT demonstrated the presence of pneumomediastinum, passive atelectasis of left lung, mediastinal and pleural fluid collection. It suggested the rupture of the esophagus resulted in mediastinitis. Emergent endoscopy showed a linear laceration with muscular exposure at lower esophagus. He underwent contrast study but esophagogram didn't show the definite leakage of contrast. The patient was treated with mechanical ventilation therapy and tube thoracostomy because he is at high risk for emergent operation due to deteriorated hypoxia and mentality. Repeated pleural taps showed a pleural empyema and pleural fluid cultures revealed to be MRSA (methicillin resistant *S.aureus*). Empirical antibiotics including vancomycin were administrated. On the 3rd admission day, weaning from mechanical ventilator was performed because his consciousness was completely alert and arterial oxygen pressure (PaO₂) was >60mmHg. A volume of pleural effusion drained through the chest tube was on the decrease. The patient was discharged with Heimlich valve instead of chest tube on the 37th admission day. Boerhaave's syndrome is uncommon but life-threatening disease. The most common etiology of BS is the perforation of esophagus followed by violent vomiting or retching. The presentations of BS are sudden onset chest pain, dyspnea, or sepsis caused by mediastinitis or pleural contamination. Thoracotomy and esophageal repair were required in most of the cases. This case shows non-operative management was safe and effective in patient with high risk of emergent operation even if there is no documentation that conservative therapy lead to a better outcome compared with surgical therapy.

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식도흉막루는 매우 드물지만, 사망률이 매우 높은 질환이다. 보통 폐절제술 후에 발생하는 경우가 많으며, 대동맥이 식도를 흉막강과 분리시키고 있으므로 좌측폐보다 우측폐에 발생하는 확률이 훨씬 높다. 발생원인으로는 식도의 침습적 수술 또는 식도의 손상, 지속적인 염증 등이 있다. 증상으로는 흉통, 연하곤란, 연하통 등이 있으며 농흉이 가장 중요한 소견이다. 식도내시경으로 진단이 가능하나 크기가 작은 경우는 발견되지 않을 수 있으므로 식도조영술을 시행하는 것이 오진을 줄일 수 있다. 치료로서는 직접적인 수술적 봉합, 보존적 치료 등 여러 가지 방법이 시행되고 있으나 만족할 만한 성과는 얻지 못하고 있으며 치료기간 중의 환자의 상태, 농흉의 조절 등이 예후에 중요한 영향을 미친다. 본 저자들은 흉통을 주소로 내원하여 농흉으로 진단받은 환자에 대한 카테터 삽관 후 발생한 식도흉막루 1예를 경험하였으며 식도스텐트 삽관 및 보존적 치료 후 호전되어 이를 보고하고자 한다.