

Case Report

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Migration of a gastric bezoar to esophagus: A rare cause of acute dysphagia

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Abstract

Sudden onset of dysphagia due to a gastric bezoar migrating to the esophagus is a relatively rare condition. A 72-year-old male patient with known gastric bezoar presented with sudden difficulty swallowing following nausea and vomiting caused by adhesive ileus. Gastroscopic examination showed a bezoar and associated compression ulcers in the esophagus. The bezoar was pushed towards the stomach and extracted by successful endoscopic fragmentation.

Keywords: phytobezoar, esophageal bezoar, dysphagia, ileus

1. Introduction

A bezoar is characterized by a hard mass formed by conglomeration of undigested food in the gastrointestinal tract. Esophagus is an uncommon site for bezoars. Here, we report a case of difficulty swallowing caused by migration of a known gastric bezoar to the esophagus in a patient with nausea, vomiting and sudden onset of dysphagia associated with the esophageal bezoar, bezoar mass and compression ulcers detected by a second endoscopic examination.

2. Case report

A 72-year-old male patient presented to the emergency department with abdominal pain, nausea and vomiting for the last 4-5 days and sudden onset of difficulty swallowing a few days ago. He was advised to admit to a tertiary healthcare facility when a gastric bezoar was detected by endoscopy a week ago. He had a history of diabetes mellitus, essential hypertension, and coronary bypass and abdominal hernia surgeries. A plain abdominal radiograph in standing position (Fig. 1a) and an abdominal CT scan showed adhesions of the small intestine secondary to the hernia surgery and dilation of intestinal loops proximally to the adhesions. An esophagogastroduodenoscopic examination was performed due to difficulty swallowing which revealed a phytobezoar (3x4 cm) localized at 34 cm from the incisors (Fig. 1b). Bezoar was pushed toward the stomach with the aid of endoscope. Deep ulcers with overlying white colored exudates and occasional millimetric hemorrhagic foci caused by compression necrosis were visualized in the esophagus at the site of the bezoar (Fig. 1c). The bezoar pushed into the stomach was endoscopically fragmented by a snare specifically

designed for bezoars and extracted with a retrieval net device (Fig. 1d). Parenteral supplementation was given and his ileus manifestations resolved on the fourth day of follow-up.

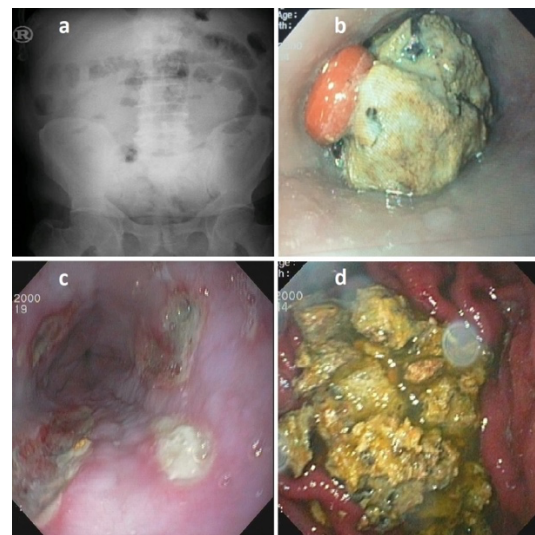


Fig. 1. Dilation of the proximal small intestine loops associated with adhesive ileus was evident on standing plain abdominal radiograph (a), phytobezoar in the esophagus containing the drug (b), ulcers caused by esophageal bezoar (c), pieces of bezoar after snare fragmentation (d)

3. Discussion

Gastric dysmotility, prior gastric surgery, gastric outlet obstruction, dehydration, anticholinergic agents, opiates, medications with insoluble protective coating and water-retaining drugs contribute to the development of gastric

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bezoars medications. Gastroparesis is frequently encountered in patients with a bezoar (Pfau and Hancock, 2016).

Bezoar in the esophagus is a rare condition. Esophageal bezoars can be divided into two groups including primary bezoars that occur in the esophagus and bezoars that are formed in the stomach and migrate to the esophagus (Chaudhry et al., 2013). Cases of esophageal bezoar have been reported in patients with impaired motility due to esophageal diverticula, diffuse esophageal spasm, achalasia, Guillain-Barre syndrome or myasthenia gravis (Chen et al., 2013; Goel et al., 1995; Kim et al., 2010). Our case is one of the rare secondary esophageal bezoars reported in the literature which caused by migration of the gastric bezoar to the esophagus, leading to nausea/vomiting and acute difficulty swallowing in the presence of adhesive ileus.

The narrow lumen of the esophagus and the risk for aspiration from fragments during the intervention make bezoars in the esophagus difficult to treat. Thus, it is more convenient to perform an overtube-assisted endoscopy for an esophageal bezoar and break it down to fragments in the stomach when possible.

Small bezoars can be treated with conservative medical approaches. A success rate of 91.3% was reported in the treatment of gastric bezoars with Coca-Cola lavages and endoscopic procedures (Ladas et al., 2013). On the other hand, larger bezoars may require endoscopic intervention or surgical treatment. Particles of the bezoar broken by endoscopic intervention can be extracted or pushed toward the small intestine. However, it should be borne in mind that fragments of a large bezoar can also result in mechanical ileus in the small intestine.

In conclusion, bezoar should be suspected in patients with relevant risk factors who report one or more symptoms of epigastric discomfort, nausea, vomiting, weight loss and early satiety and it should be considered that bezoar may cause sudden difficulty swallowing.

Conflict of interest

None to declare.

Acknowledgments

None to declare.

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