Unhappy obstruction (answers on page 44)

Part one

Mary, at 75, had always enjoyed good health. In fact she was proud of the fact that she 'had only seen her doctors for her pregnancies' around 50 years before. She was a 'well-rounded' lady (in fact frankly obese) who normally laughed a lot, but on the day she finally came to her doctor she wasn't laughing. In fact she was very distressed, feeling very sick and retching, but unable to vomit. She was not in pain, and she had passed a normal stool that morning. Between her bouts of retching she admitted to having had 'trouble swallowing' for the previous three weeks. She had only been able to swallow small amounts of water and other liquids, but no solids, and was constantly belching. She thought that she had lost 7 kilograms in weight over the last three weeks. Asked why she had waited so long before coming to the doctor, she shrugged, saying that she had thought 'it would settle down'.

Q1 Given that the symptoms appear to be of a gastro-intestinal tract obstruction, which of the following would you consider as among the likely causes?

a) Oesophageal carcinoma
b) Gastric tumour
c) Prepyloric stenosis due to ulcer
d) Oesophageal motility disorder such as presbyo-oesophagus
e) Hiatus hernia-related obstruction
f) Acute infective gastritis

On further questioning Mary admitted to having had a few problems for a 'year or so', in that she had had occasional heartburn, for which she had self-medicated with proprietary antacids. She had a garden, and had stopped bending over because it would cause 'sour tasting stuff' to well up in her mouth. She had taken to sleeping on four pillows, instead of her former two.

Part two

Q2 Examination revealed that she was severely dehydrated and had a heart rate of 120 per minute. She was afebrile. Her abdomen was soft with no areas of tenderness. Apart from her tachycardia, she had no signs of heart disease. Her breath sounds were normal. A chest X ray and chest and abdominal CT scans highlighted the cause of her distress. They showed that there was a large air-filled mass in her posterior mediastinum, divided by a septum. Which of the following was the radiologist's diag nosis?

a) Hydatid cyst causing compression of the oesophagus
b) Para-oesophageal hiatus hernia with obstruction at the diaphragm
c) Gastric volvulus linked to hiatus hernia
d) Lymphoma arising from the mediastinum
e) Oesophageal cancer with para-oesophageal spread

Part three

Q3 It proved extremely difficult to pass a naso-gastric tube into the stomach, so Mary was rapidly rehydrated with intravenous fluids and her subsequent treatment was highly successful in relieving her symptoms. Which of the following was the effective treatment?

a) Bed rest and intravenous fluids until the episode settled, followed by long term medication for hiatus hernia and oesophagitis.
b) Once rehydrated and with electrolyte correction, urgent surgery, either open or laparoscopic.
c) Surgery is contraindicated: along with rehydration and rest she needed anti-emetic medication and sedation, with further investigations of the nature of the mediasti nal mass.
d) After rehydration, referral to the oncology department for more detailed diagnosis and assessment of the stage and prognosis of her disease
e) Referral to the thoracic surgeon for assessment of possible complete excision of her cyst

Part four

Q4 During the investigations Mary was found also to have Barrett's oesophagus. Which of the following statements are true of this condition and its possible consequences?

a) It is the main risk factor for oesophageal cancer
b) It is caused by acid reflux into the oesophagus, usually from hiatus hernia
c) The conversion rate from Barrett's oesophagus to oesophageal adenocarcinoma is 0.5% per year.
d) The conversion to cancer occurs, on average, within 15 years of Barrett's oesopha gus being diagnosed.
e) Oesophageal cancer has an 80% 5-year mortality from the time of diagnosis.