



## Acute esophageal necrosis – A rare and striking entity

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### Description

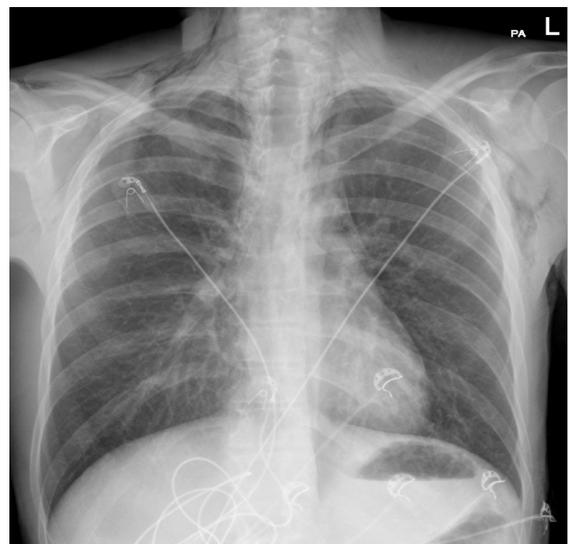
A 28-year-old male presented to the emergency department with intractable vomiting and retrosternal chest pain on a background of poorly controlled type 1 diabetes mellitus. Laboratory investigations demonstrated a neutrophilic leukocytosis as well as elevated blood glucose (18) and ketones (4.6), serum lactate was normal at 1.2. A diagnosis of evolving diabetic ketoacidosis was made and initial management with glucose control and hydration commenced.

A chest X-ray performed (Figure 1) in the Emergency Department demonstrated significant subcutaneous emphysema. Subsequent computed tomography of the thorax showed extensive pneumomediastinum with a locule of intramural gas possibly reflecting a focal rupture point (Figure 2).

An emergency Oesophago-gastro-duodenoscopy (OGD) was performed which demonstrated a black oesophagus with an abrupt and striking cut-off at the oesophago-gastric junction (Figure 3). A diagnosis of Acute Esophageal Necrosis (AEN) was made.

The patient was managed conservatively with bowel rest and total parenteral nutrition for a total of 2 weeks. A gastrograffin swallow was performed after 7 days demonstrated no persistent leak. A repeat OGD 14 days later demonstrated a marked improvement with near complete resolution (Figure 4).

Although a rare entity, AEN should be considered in the setting of chest pain especially on a background of diabetes mellitus and intractable vomiting. Failure to diagnose and commence appropriate management can result in significant morbidity and mortality. Oesophageal stricture formation is seen in up to 10% of patients following AEN, therefore adequate clinical follow-up is vital.



**Figure 1:** Chest X-Ray.



Figure 2: CT Thorax.

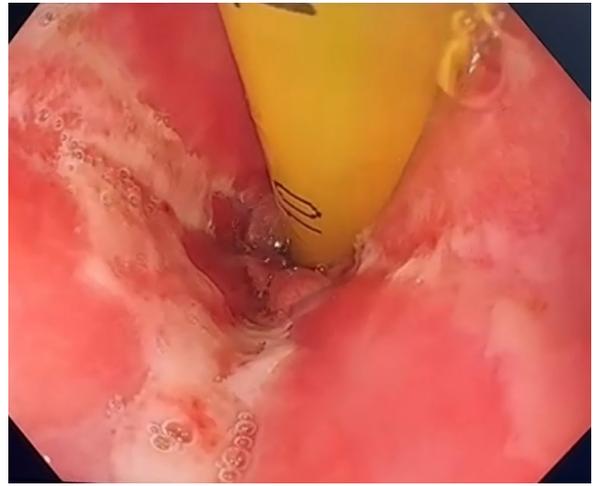


Figure 4: OGD\_2.



Figure 3: OGD\_1.