A PECULIAR CASE OF OESOPHAGEAL DILATATION.

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THE following very remarkable case of oesophageal dilatation in an achondroplastic dwarf seems to be worthy of a full report.

H. G. first came under my notice on July 26th, 1905, at the age of 33. He presented the typical appearances of achondroplasia, but it is not necessary to enlarge upon them, as it is not with reference to this disease that the case is reported.

First Residence in Hospital.

His occupation was that of a tailor, and he had enjoyed very fair health all his life till the last two or three years, when he began to have symptoms off and on of difficulty in digesting his food. He complained of pain after food, and of frequently vomiting his food almost immediately it had been taken. There was no history of vomiting blood or of melaena. The stomach showed no appearance of dilatation downwards, but came up in the axilla to the third rib.

The patient vomited nearly every day at first; the food appeared to return undigested, and did not smell of the gastric juice, but the vomit was acid. An oesophageal bougie was arrested 17 in. from the teeth, and on attempting to wash out the stomach with a stomach tube, the tube was arrested at the same distance from the teeth and the fluid came back

Fig. 1.—Diagram of post-mortem appearance of stomach and oesophagus. o, Oesophagus; sp, spine; s, stomach.

immediately, quite clear and not at all acid. Mapping out the stomach with carbonic acid gas showed only slight dilatation.

The diagnosis seemed to be stricture of the oesophagus at the cardiac orifice with subsequent dilatation. The cause of the stricture was, however, very doubtful; the age of the patient and duration of the symptoms was rather against malignancy, and there was no history of ever having swallowed some corrosive. I came to the conclusion that there was possibly some congenital narrowing at the cardiac orifice, and called in my surgical colleague, Dr. R. A. Milligan, with the idea of asking him whether it would be possible to open the stomach and dilate the cardiac orifice from below. The alternative diagnosis was that the patient had a large oesophageal pouch. Dr. Milligan succeeded in passing a small bougie into the stomach, but a larger one doubled up above the stricture. His opinion was that it would be better not to operate.

With careful dieting the patient in the course of two months improved very considerably, and went out of the hospital in a fairly well-nourished condition, although he still vomited from time to time—about once in three to five days.

Second Residence in Hospital.

Nothing more was then heard of the patient till March 31st, 1909, when he reappeared at the hospital. He then reported that he had kept fairly well for some time, but that then his symptoms had gradually returned and that now he could keep nothing down at all. He complained of pain and fullness in the chest after meals, and that then shortly all the food was returned. He complained of great thirst and emaciation and that the bowels were very costive.

The stomach was not dilated, but came high up into the axilla, this time to the fourth rib; on both sides of the thoracic

vertebrae behind from a little above the angles of the scapulae downwards there seemed to be a rather hyper-resonant note. All bougies, even the smallest, were arrested 17 in. from the teeth.

A bismuth meal was given and my colleague, Dr. W. M. Robson, kindly took an x-ray photograph of the thorax for me. The photograph when developed showed a marked shadow extending well to the right of the spine and reaching far up towards the clavicle. This seemed to point to the curious fact that the pouch or dilatation of the oesophagus was on the right side of the spine and not on the left. The food vomited was distinctly acid.

Under a course of purgatives and dietetic treatment as for a gastric ulcer, the patient made a complete recovery for the time being. He gained 13 lb., and left the hospital having not vomited for the last fifteen days. He was then able to take minced chicken, minced mutton, eggs, etc.

Third Residence in Hospital.

The patient made his appearance at the hospital for the last time on September 28th, 1909. He looked very emaciated, weak, and collapsed, and reported that his symptoms had recurred almost immediately after leaving the hospital in May, and that he had vomited nearly every day since that time.

On this occasion the stomach appeared to be distinctly dilated downwards nearly to the umbilicus.

No treatment was of any avail, and the patient rapidly sank and died, apparently from starvation, on October 20th, 1909.

Post-mortem Examination.

The oesophagus was to the right of the spine, greatly dilated and obscurely sacculated in its whole length. The muscular walls were greatly thickened and also the mucous membrane, which, however, was quite smooth and not congested. The walls of the oesophagus were considerably thicker than the walls of the stomach.

To gain the stomach the oesophagus crossed the spine at a

Fig. 2.—Diagram of x ray photograph after a bismuth meal. s.o, Shadow of dilated oesophagus; h, heart.

right angle, as in the accompanying sketch (Fig. 1). The mucous membrane of the oesophagus showed no sign of ulceration, new growth, or any stricture. The cardiac opening of the stomach admitted the middle finger of the hand. There was much debris of food in the oesophagus, very little in the stomach. Fluid poured into the oesophagus seemed to pass with difficulty into the stomach.

What was the origin of this curious condition seems to be doubtful. If the position of the oesophagus on the right side of the spine was a congenital anomaly, then probably the whole condition may be explained by the fact that the oesophagus had to cross the spine at a right angle to gain the stomach.

Food would tend to accumulate at the kink, and hence sagging and kinking would occur with the final result of a relatively complete obstruction.

The case might conceivably, however, have been one of the more ordinary cases of idiopathic dilatation of the oesophagus, due possibly either to cardiospasm or paralysis of the longitudinal muscle of the oesophagus. It is, perhaps, not impossible that under such circumstances the oesophagus should finally get displaced across the spine owing to the increasing weight of food within it. The mature age at which the patient died seems to be rather in favour of the second theory, as it seems unlikely that such a serious congenital malformation as the first theory would involve would have permitted the patient to reach adult life.