

A distinctive case of dysphagia

A 73-year-old woman described a 2-year history of solid foods “getting stuck” once or twice per week. The sensation was not progressive, and she denied heartburn, regurgitation, weight loss, fever, hemoptysis and melena. She did not drink or smoke and had no history of muscle weakness or respiratory illness. On physical examination she appeared well nourished and was not jaundiced. Head, neck, respiratory and abdominal examinations were unremarkable. She had no lymphadenopathy, rash or focal neurologic findings.

A chest radiograph (Fig. 1) suggested a large retrocardiac mass (black arrows) of uncertain origin. A CT scan of her chest with oral contrast medium (Fig. 2) showed a soft-tissue mass containing gas loculi (white arrow) 10 cm below the carina. A barium swallow (Fig. 3) revealed a diverticulum measuring 3 × 5 × 5 cm in the lower esophagus, just above the gastroesophageal junction, that contained food debris but no stricture, mass or me-

chanical obstruction. Upper gastrointestinal endoscopy (Fig. 4) confirmed the presence of a large diverticulum (yellow arrow) extending from the esophageal lumen (white arrow and white line) that contained undigested food debris but no evidence of erosion, inflammation or dysplasia. Because the patient’s symptoms were relatively minor, no treatment was initiated.

Although the first case of an esophageal diverticulum was reported nearly 250 years ago,¹ remarkably little is known about this condition. It affects an estimated 0.02% to 0.77% of people, most of whom are asymptomatic.² Of all patients who present with dysphagia, 1%–3% have an esophageal diverticulum as the identified cause (more common causes include benign strictures, esophageal rings or webs, tumours and motility disorders such as achalasia). Most patients present in the sixth and seventh decades of

life with dysphagia or regurgitation, but other common symptoms include cough, halitosis and laryngitis. Life-threatening complications (e.g., aspiration pneumonia, stridor, cardiac arrhythmias, cancer and diverticular rupture) are rare.

Diverticula are classified according to their location:³ Zenker’s diverticula are pharyngeal outpouchings just above the upper esophageal sphincter, mid-esophageal diverticula are within 5 cm of the carina, and epiphrenic diverticula are in the distal 10 cm of the esophagus.

Esophageal diverticula may develop when the esophagus is pushed or pulled abnormally. Increased hypopharyngeal pressure may lead to Zenker’s diverticula. Similarly, “pulsion” forces associated with esophageal motility disorders, such as diffuse esophageal spasm, may result in epiphrenic diverticula. In contrast, mid-esophageal diverticula are associated with “traction” forces, often from a local inflammatory process such as tuberculosis.

The natural history of these lesions is debatable, but most patients can be followed symptomatically and require no specific therapy. Surgery is usually reserved for people with significant progressive dysphagia or recurrent aspiration pneumonia.⁴

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References

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