MALLORY–WEISS SYNDROME AND INTRAMURAL OESOPHAGEAL

MALLORY–WEISS SYNDROME AND INTRAMURAL OESOPHAGEAL HAEMATOMA/DISSECTION

Forceful vomiting may lead to a tear at the OGJ, mostly imme diately below the squamocolumnar junction. Patients present with haematemesis. Bleeding is rarely severe, and the diagnosis George Kenneth Mallory , 1900–1986, pathologist, Boston University , Boston, MA, USA. Soma Weiss , 1898–1942, Physician in Chief, Peter Bent Brigham Hospital, Boston, MA, USA. is readily made with endoscopy . Endoscopically the bleeding can be stopped by adrenaline (epinephrine) injection or endo - - scopic clips to stop bleeding and close the mucosal defect. Intramural oesophageal dissection is characterised by the separation of the mucosa and/or submucosa from deeper m us - cular layers. This most commonly occurs in elderly patients taking anticoagulants or patients with coagulation disorders. It is often precipitated by vomiting. A break in the oesoph - ageal mucosa is followed by an incr ease in intraoesophageal pressure that causes separation of mucosa and/or submucosa from the muscle layers. The mucosal break can also be caused by trauma such as foreign body impaction or air insu ffl ation during endoscopy . Patients present with acute onset of chest discomfort or odynophagia. If the haematoma ruptures into the oesoph - ageal lumen haematemesis ensues. When the dissection or haematoma is confined to the oesophageal wall, treatment is conservative. Anticoagulation is corr ected and the haematoma usually resolves in 7–14 days.

Stent for oesophageal perforation. (a) Leakage of oral contrast outside the (b) contrast /f_l owing through the stent, no leakage is seen.

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