CLINICAL VISTAS

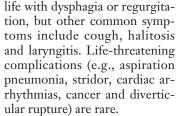
A distinctive case of dysphagia

73-year-old woman de-Ascribed 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 $3 \times 5 \times 5$ 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

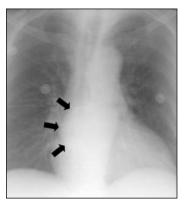


Diverticula are classified according to their location: ³ Zenker's diverticula are pharyngeal outpouchings just above the upper esophageal sphincter, midesophageal diverticula are within 5 cm of the carina, and epiphrenic diverticula are in the distal 10 cm of the esophagus.

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, midesophageal diverticula are associated with "traction" forces, often from a local inflammatory process such as tuberculosis.

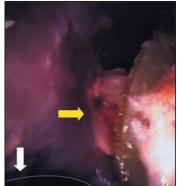
The natural history of these lesions is debatable, but most patients can be followed symptomatically and require no specific therapy. Surgery is usually reserved for people with significant progressive dysphagia or recurrent aspiration pneumonia.⁴











References

- Chitwood WR Jr. Ludlow's esophageal diverticulum: a preternatural bag. Surgery 1979;85:549-53.
- Thomas ML, Anthony AA, Fosh BG, Finch JG, Maddern GJ. Oesophageal diverticula. Br J Surg 2001;88:629-42.
- Baker ME, Zuccaro G Jr, Achkar E, Rice TW. Esophageal diverticula: patient assessment. Semin Thorac Cardiovices Symp 1090;11:376-36.
- vasc Surg 1999;11:326-36.
 4. Fekete F, Vonns C. Surgical management of esophageal thoracic diverticula.

 Hepatogastroenterology 1992;39:97-9.