



IMAGES IN THORAX

An unusual case of respiratory arrest

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Received 26 March 2015

Accepted 4 April 2015

Published Online First

8 May 2015

A 38-year-old non-smoker was found by paramedics holding on to a salbutamol inhaler. Examination showed generalised reduced air entry but no wheeze. She was initially treated as having an acute exacerbation of asthma with nebulisers and intravenous steroid. On arrival at A&E, the patient deteriorated further and went into respiratory arrest. She was intubated and ventilated. A chest X-ray (figure 1) was performed, which showed a right upper zone area of lucency and a CT thorax (figure 2) was reported as showing grossly dilated oesophagus containing food residue and marked compression of trachea below the endotracheal tube. A nasogastric tube was subsequently inserted and food residue was aspirated. An oesophago-gastro-duodenoscopy performed post extubation did not show any physical obstruction. The patient was subsequently referred to a tertiary centre for a myotomy.¹

LEARNING POINT

Megaesophagus leading to tracheal compression is a rare manifestation of achalasia. A previous case report describes that the first case was documented in the 1950s and only 50 cases have been documented since then.

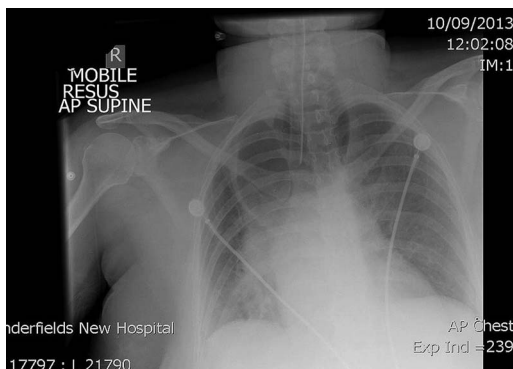


Figure 1 Chest X-ray showing right upper zone lucency.



Figure 2 CT thorax showing dilated oesophagus with marked trachea compression.

A major learning point in this case was the presumption of asthma. The patient had a known history of achalasia and no history of asthma. The inhaler that the patient was using actually belonged to her partner who gave a collateral history of increased chest discomfort and regurgitation particularly after a meal for the preceding week. This shows the importance of getting a background on a patient though it was noted that the patient was peri-arrest on arrival to A&E.

Contributors VC (main guarantor) plan, conduct and co-reported with JA. SS proof read this article.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; internally peer reviewed.

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To cite: Chew V, Azam J,
Shah S. *Thorax*
2015;**70**:1098.

