Mallory Weis Tear At Lower End of Esophagus - Case Report

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Abstract- *Mallory Weiss Tear takes place in the gastro-esophageal junction with longitudinal, non-perforating superficial lacerations and are mostly seen in case of upper gastrointestinal bleeding situations. By the year 1929, Kenneth Mallory and Soma Weiss first illustrated a syndrome characterized by esophageal bleeding caused by mucosal tear in the esophagus resulting in vomiting. MWS symptoms include Abdominal pain, Hematemesis, frequent belching, nausea, throat soreness, general weakness with dizziness, diarrhea. In this study the patient was presented with chief complaints of hematemesis, epigastric pain and was chronic alcoholism(360ml/day). Patient was initially treated with IV fluids, antacids and antiemetics.*

Keywords- Mallory Weiss Tear, Hematemesis, Chronic alcoholism.

I. INTRODUCTION

Mallory Weiss Tear takes place in the gastro-esophageal junction with longitudinal, non-perforating superficial lacerations and are mostly seen in case of upper gastrointestinal bleeding situations.[1] By the year 1929, Kenneth Mallory and Soma Weiss first illustrated a syndrome characterized by esophageal bleeding caused by mucosal tear in the esophagus resulting in vomiting. Mallory-Weiss syndrome is accountable for approximately 3-11% of Upper - GI bleeding.[2]

Regular early endoscopic examination of the esophagus and stomach in patients with bleeding from the upper gastro-intestinal tract results in a marked increase inside the frequency with which the characteristic esophagogastric laceration is detected and in multiplied cognizance of the opportunity of its life in all instances of upper gastrointestinal bleeding. Accurate analysis leads to right treatment, whether or not operative or unoperative. The occasional incorrect endoscopic prognosis needs no longer delay right remedy.[3]
Most of the time, the hemorrhage in MWT is moderate and self-limited, with patients benefiting from conservative clinical treatment (such as fasting, bed relaxation, antiemetics, sedation, intravenous antacids and somatostatin as well as blood transfusion).[4]

Patients with active bleeding and co morbid illnesses want immediately hemostatic and the quality treatment i.e., interventional endoscopy, some different patients require combination treatment like epinephrine or vasopressin injection, band ligation, electro coagulation and hemo clip therapy. [5]

CASE REPORT:

A 35-year male alcoholic(360ml/day) presented with the chief complaints of severe epigastric pain, multiple episodes of blood vomiting's(15-20episodes). He reported 5 episodes of melena in 24 hours period of duration. On physical examination blood pressure-110/70mmHg, Pulse rate-80bpm, Respiratory System-Bilateral air entry positive. Upon admission, the patient underwent complete blood examination which was remarkable for hypochromic with diminished levels of hemoglobin-6.9g/dl, hematocrit -25%, mean corpuscular volume-75fl, Red Blood Cells: 4.7 m/Ul, WBC:10.8thousands/cumm, Platelet count: 151 thousands/cumm, neutrophils: 75%, lymphocytes: 20%, eosinophils: 1%, monocytes: 4%, basophils: 0%. ESR 1st and 2nd hour: 42 mm/hr and 86 mm/hr., Liver Function Test: Total Bilirubin: 1.8 mg/dl, Direct Bilirubin: 0.6 mg/dl, SGOT: 76 IU/L, SGPT:137 IU/L, Serum Alkaline Phosphatase: 100 IU/L, Total Protein: 7 gm/dl, Serum Albumin: 3.5 gm/dl, Globulin: 2.9, Random Blood Sugars: 138 mg/dl, Serum Urea: 61 mg/dl, Serum Creatinine: 0.8 mg/dl, Serum Sodium: 132mmol/L, Serum Potassium: 4 mmol/L, Serum Chloride: 97 mmol/L, Complete Urine Examination: Colour: Pale Yellow, Volume: 15 ml, Reaction: Acidic, Pus cells: 3-5 HPF, Epithelial cells: 2-3 HPF. %. In Ultrasound scan of abdomen there was an impression of Grade-2 fatty liver and in Upper GI endoscopy report there was an impression of esophageal varices with altered blood in stomach and lower end of esophagus.

DISCUSSION:

Patient was admitted in hospital due to 15-20episodes of hematemesis and was having severe epigastric pain and was having a social history of chronic alcoholism(360ml/day). On the first day of hospital admission patient was advised for NMB (Nil by mouth). Doctor advised laboratory test such as complete blood picture, Liver function test, complete urine examination, Upper GI endoscopy, Ultrasound scan of abdomen. The initial management of patient with upper GI bleeding includes checking hemodynamic instability, patient stabilization with Intravenous fluid resuscitation and blood transfusion.[6] In most of the cases, these bleeding manifestations from an MWT is not severe and may stop without a treatment but in few cases hemostasis and hospitalization is required.[7] Medications that enhance the bleeding manifestations are to be withdrawn immediately. Patient was treated with IVF-25%Dextrose,2pint Normal Saline with 50ml/hr,1 pint ringer lactate with 50ml/hr, 2pint pack transfusion, Inj.Tranexa-1g/IV/BD, Inj.Terlipressin-1mg/IV/Bd, Inj.Pan-80mg in 100ml Normal saline i.e., 8ml/hour -infusion, Inj Zofer-40mg/TID. On day-3 of admission, patient had a chief complaints of blood vomiting -5episodes for which Inj.Tranexa-500MG/IV/BD was prescribed. Further on episodes of vomiting were subsided. On day-5 the patient was discharged with Tablet.Zofer-4mg TID for 4days, Tab.Pantoprazole-40mg/OD BBF for 4 days, Syrup Sucral-10ml/TID for 10days. The patient experienced remission of symptoms and generalized improvement and was able to be discharged. The patient was also counseled to cease consuming alcohol immediately and indefinitely.

II. CONCLUSION

Patient was having a social history of chronic alcoholism(360ml/day), before the hospital admission patient had 15episodes of hematemesis and epigastric pain. Due to excessive consumption of alcohol by the patient it leads to hematemesis and tear of esophagus which are ultimately the primary reason for Mallory Weiss condition. Ultrasound scan of abdomen and upper GI endoscopy was being performed which reflects the impression of Grade-2 fatty liver and esophageal varices with altered blood in stomach and lower end of esophagus. On discharge the patient was treated with antacids, antibiotics, antiemetics. Vomiting, particularly protracted or forceful vomiting, can be associated with tears of the proximal stomach mucosa (Mallory–Weiss tear) and is common in chronic alcoholics.

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