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An Unusual Case of Dysphagia Due to a Pancreatic Cause: Can We Call It “Dysphagia Pancreatica”?

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Abstract

Difficulty in swallowing, dysphagia, is caused by several etiologies. It can rarely be caused by pancreatic pathology, such as pancreatitis with a collection or pancreatic cancer extension causing esophageal compression, as described in the literature. We hereby describe a case of dysphagia due to a pancreatico-esophageal fistula.

A 42-year-old male without any comorbidities presented with sudden-onset difficulty in swallowing and chest pain of 2 days' duration. He had mild epigastric tenderness on examination. ECG was normal, as was troponin-I. Serum amylase was elevated (560 IU/mL). Abdominal ultrasound showed features of acute pancreatitis. Since he had significant alcohol intake, acute pancreatitis due to alcohol consumption was considered. Endoscopy revealed a smooth esophageal bulge with luminal narrowing. Since it appeared to be an extrinsic compression, on-table EUS was performed, which showed changes of pancreatitis with a collection containing thick contents extending into the submucosal space of the esophageal wall across the gastroesophageal (GE) junction. MRI showed similar findings of changes of pancreatitis with a collection tracking into the esophageal wall.

He was managed conservatively with analgesics and a liquid diet. He showed gradual resolution of symptoms and was tolerating a regular diet at early follow-up. This case was an unusual presentation of pancreatitis with chest pain and dysphagia. Since the dysphagia was due to pancreatitis and a collection entering the esophageal wall, it may aptly be termed "dysphagia pancreatica."

Six months later, he presented to the ED with fever, dyspnea, and chest pain. Clinically, he was noted to have a fever, tachypnea, and tachycardia. A massive left pleural effusion was suspected due to absent breath sounds. Chest X-ray confirmed a massive pleural effusion, and CT of the chest with abdominal cuts showed a pancreatic collection communicating with the left pleural cavity, with a massive pleural effusion. An intercostal drain (ICD) was immediately placed into the left chest, and he was continued on oxygen supplementation along with broad-spectrum antibiotics and octreotide. On further questioning, the patient admitted to having another episode of binge drinking, which could explain the recurrence of pancreatitis with complications.

Pleural fluid amylase was >10,000 IU/mL, supporting a pancreatico-pleural fistula (PPF). Despite ICD placement and antibiotics, persistent drainage of 500 mL-1 L/day necessitated EUS-guided pancreatic collection drainage by cystogastrostomy.

Following EUS-guided cystogastrostomy, the drainage volume gradually decreased, and the ICD was removed after five days. After documenting the resolution of the pleural effusion and pancreatic collection on follow-up, the cystogastrostomy stents were removed, and he subsequently made a complete recovery within six weeks.

This index case is an unusual presentation of pancreatitis with dysphagia due to a collection entering the esophageal wall, i.e., a pancreatico-esophageal fistula, which has not been reported yet. Previously, cases of pancreatic collections/pseudocysts in the mediastinum compressing the esophagus and causing dysphagia have been reported. As there was intramural extension of pancreatic fluid causing dysphagia, the term "dysphagia pancreatica" may be apt. A multimodal approach helped manage this critically ill patient with a good outcome.

Categories: Therapeutics, Pulmonology, Gastroenterology
Keywords: dysphagia, dysphagia pancreatica, intercostal drainage, intramural collection, pancreatico-esophageal fistula, pancreatico-pleural fistula, pancreatitis, therapeutic eus

Introduction

Difficulty in swallowing (dysphagia) can be due to mechanical causes such as strictures, webs, tumours, or aberrant vessels obstructing or compressing the esophageal lumen [1,2]. It can rarely be caused by pancreatic pathology, such as pancreatitis with fluid collection [3,4,5,6,7] or pancreatic cancer extending into the mediastinum, causing extrinsic esophageal compression [8]. Inflammatory disruption of the pancreatic duct leads to leakage of pancreatic secretions. Anterior ductal disruption often results in pancreatic ascites, whereas posterior ductal disruption results in a thoracopancreatic fistula [4]. The extension of a pancreatic collection into the mediastinum, typically tracking through the esophageal or aortic hiatus of the diaphragm and compressing the esophagus from outside the esophageal wall, causing dysphagia, has been reported previously [4,5,6,7,9,10]. The fluid could also track into the pleural cavity, leading to pleural effusions [11,12]. We hereby describe an unusual case of a 42-year-old male without any comorbidities who presented with dysphagia and chest pain due to ethanol-related acute pancreatitis complicated by a fluid collection that dissected into the esophageal submucosa, leading to a pancreatico-esophageal fistula and compromising the esophageal lumen. A collection extending into the esophageal wall and causing such symptoms has not been described previously. Since the dysphagia is due to a pancreatic cause, we would like to propose the term "dysphagia pancreatica."

Case Presentation

A 42-year-old male without any comorbidities presented with acute-onset difficulty in swallowing (dysphagia) and chest discomfort of 2 days' duration. On clinical examination, he was stable, with mild tenderness in the epigastrium. The ECG was normal, as was troponin-I. Serum amylase was elevated (560 IU/mL). Abdominal ultrasound showed changes of pancreatitis with an ill-defined collection. The patient had significant ethanol consumption prior to the event. Ethanol-related moderate pancreatitis was diagnosed. Since he complained of dysphagia, endoscopy was performed, which revealed a smooth esophageal bulge with luminal narrowing. Since it appeared to be extrinsic compression, on-table EUS was performed, which showed changes of pancreatitis with a fluid collection containing thick material extending into the submucosal space of the esophageal wall across the gastroesophageal (GE) junction, a pancreatico-esophageal fistula, as shown in Figure *1*. Since it was an immature collection with thick debris, drainage was not considered. Conservative management was considered. MRI showed similar findings of acute pancreatitis with a collection tracking into the esophageal wall, as seen in Figure *2*.

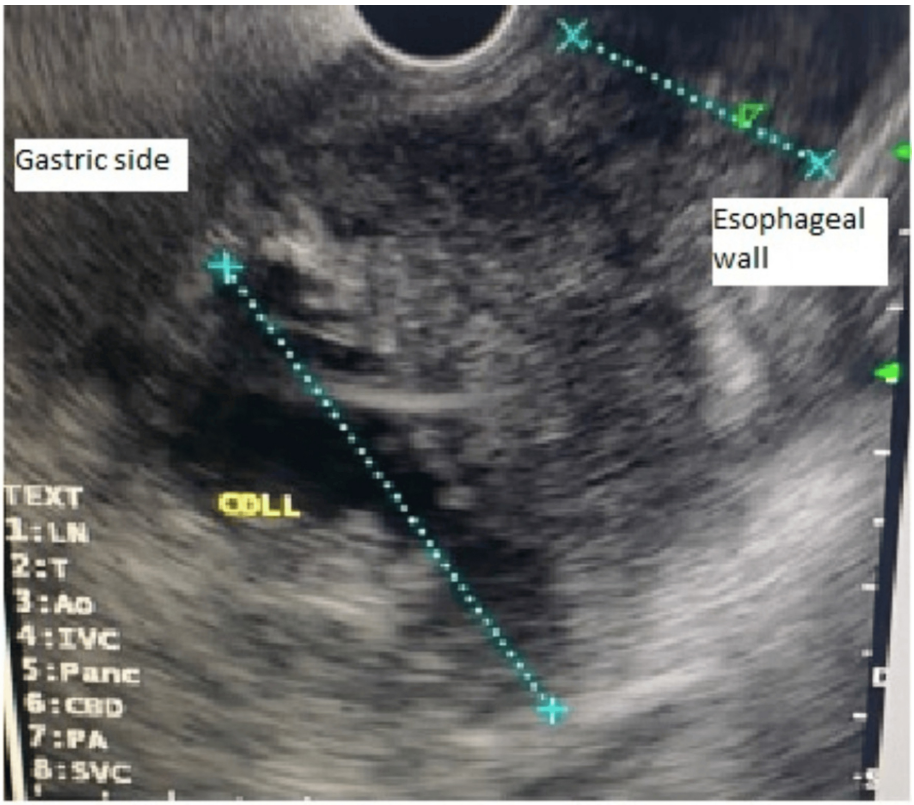


FIGURE 1: EUS showing a 6 × 4 cm pancreatic collection WOPN tracking into the esophageal wall.

WOPN: Walled-off pancreatic necrosis; EUS: Endosonography.

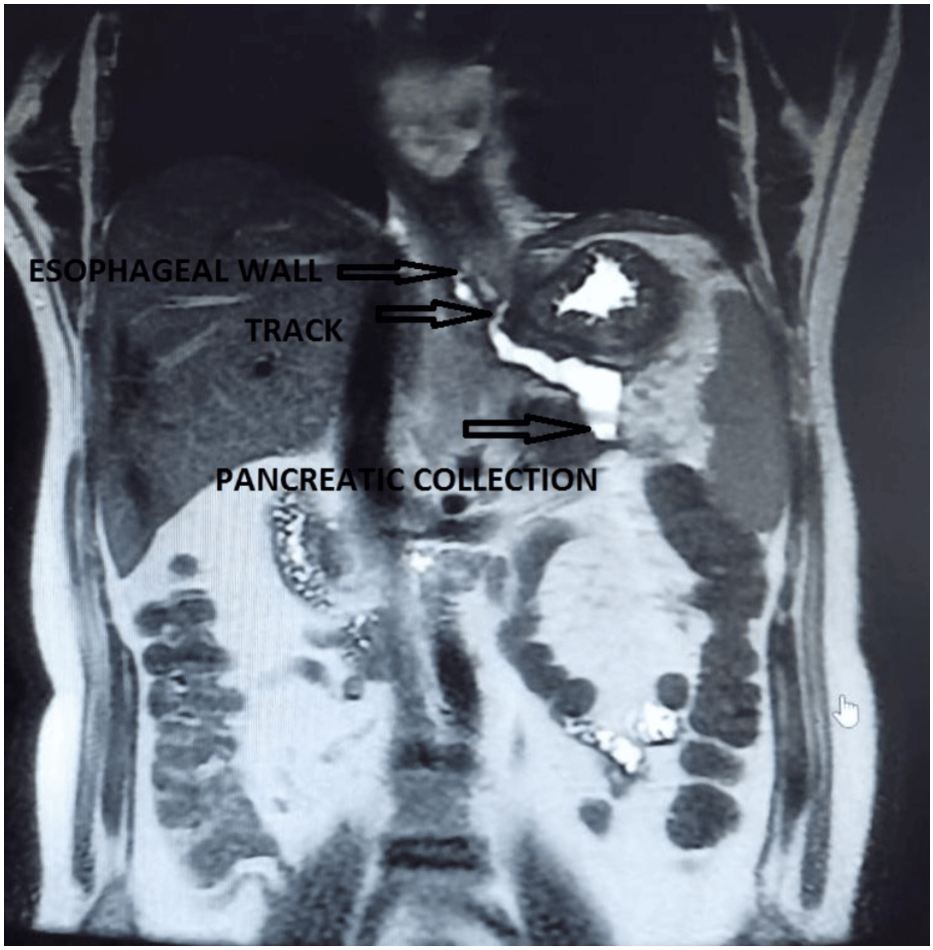


FIGURE 2: MRI showing a pancreatic collection WOPN tracking into the esophageal wall.

WOPN: Walled-off pancreatic necrosis.

He was managed conservatively with a liquid diet, IV analgesics, and octreotide. He showed gradual resolution of symptoms and was discharged. He was tolerating a regular diet at early follow-up. This case was an unusual presentation of pancreatitis with chest pain and dysphagia. Since the dysphagia was due to pancreatitis and a collection tracking into the esophageal wall rather than compressing the esophagus externally, it may aptly be termed "dysphagia pancreatica."

Follow-up of the patient

Six months later, he presented to the ED with fever and sudden-onset shortness of breath accompanied by chest pain. Clinically, he was noted to have a fever, tachypnea, and tachycardia. A massive left pleural effusion was suspected due to absent breath sounds. ECG showed sinus tachycardia. Troponin-I was normal. Chest X-ray confirmed a massive pleural effusion, and CT of the chest with abdominal cuts showed a recurrence of pancreatitis and a pancreatic collection communicating with the left pleural cavity, with a massive pleural effusion, as shown in Figure *3*. A percutaneous drain was immediately placed into the left chest, which revealed purulent effusion, i.e., empyema. Antibiotic therapy was escalated to a cefoperazone-sulbactam combination, and oxygen supplementation was continued. The patient had a recent episode of binge drinking preceding this second episode of pancreatitis.

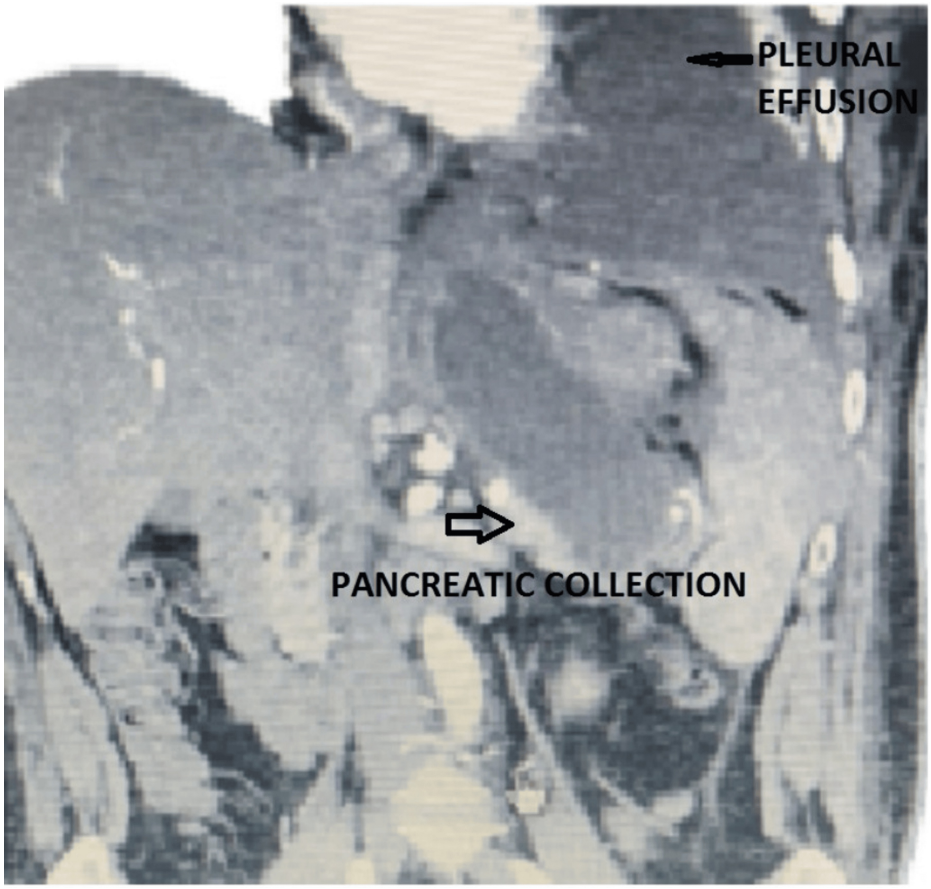


FIGURE 3: CT of the abdomen showing a pancreatic collection and left pleural effusion.

Pleural fluid analysis showed high amylase levels (>10,000 IU/mL), confirming a pancreatico-pleural fistula (PPF). Despite intercostal drainage (ID) and broad-spectrum antibiotics, persistent drainage of nearly 500 mL/day necessitated endoscopic ultrasound (EUS)-guided pancreatic collection drainage, as depicted in Figures *4*-*5*.

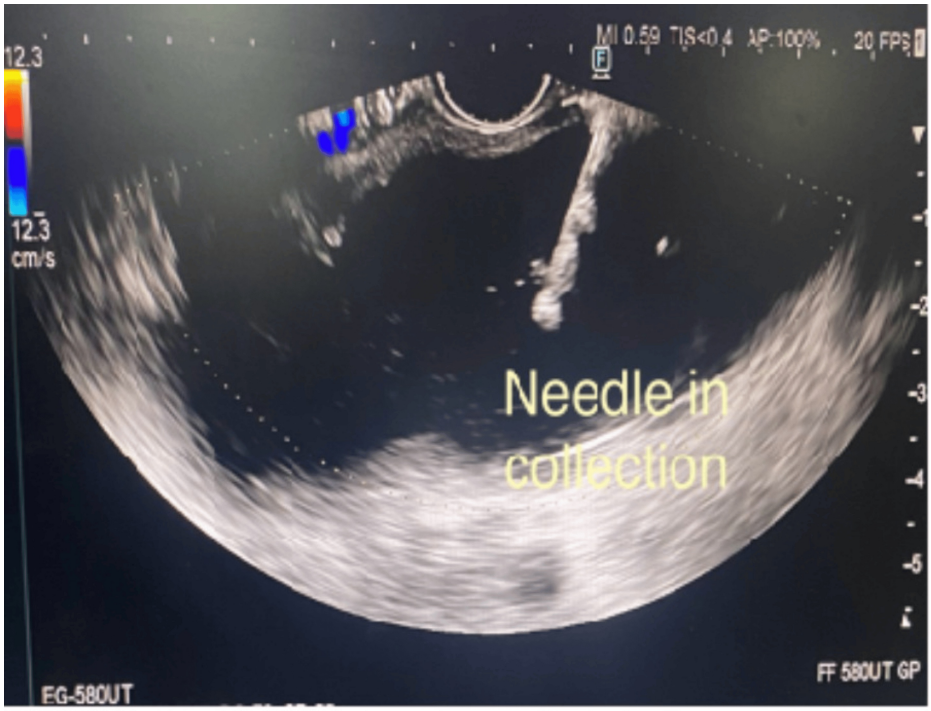


FIGURE 4: EUS image showing needle puncture of the pancreatic collection.

EUS: Endosonography.

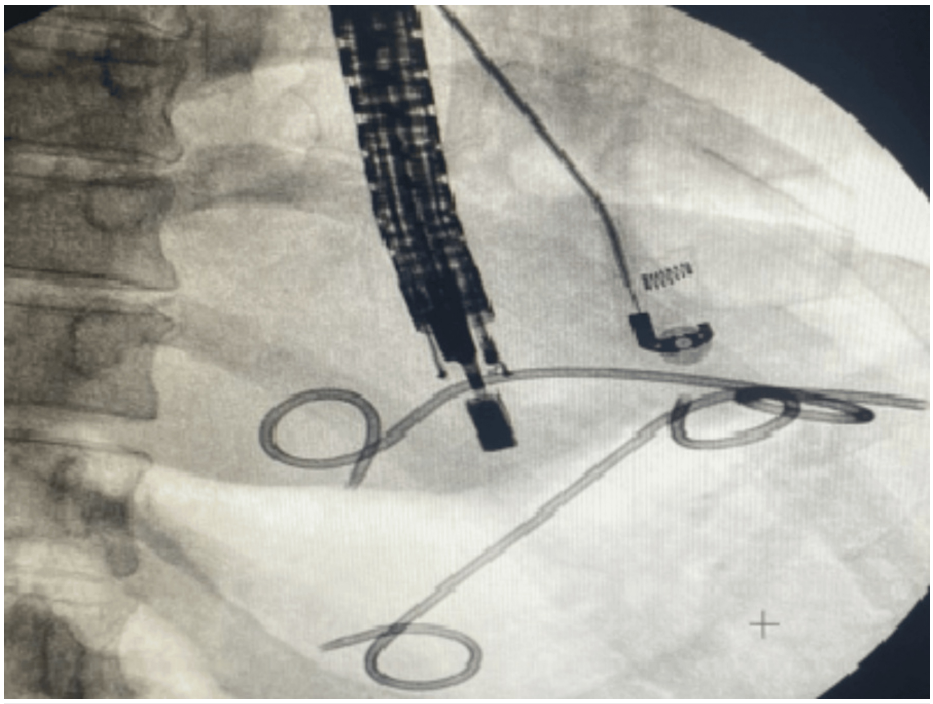


FIGURE 5: Fluoroscopic image showing cystogastrostomy with plastic pigtail stents.

Following EUS-guided cystogastrostomy, the drainage volume gradually decreased from 500 mL-1 L/day to <10 mL/day over the next five days, after which the ICD was removed. After documenting the resolution of the pleural effusion and pancreatic collection on follow-up, the cystogastrostomy stents were removed, leading to complete recovery within six weeks. The patient was doing well at follow-up.

This case is an unusual presentation of pancreatitis with dysphagia due to a collection entering the esophagus intramurally. To date, there have been case reports of pancreatic collections extending into the mediastinum and externally compressing the esophagus, but in our case, there was intramural extension of the collection, which has not been described previously. Hence, we would like to report this case and label the disorder as "dysphagia pancreatica," which may be an apt term. A multimodal approach helped manage this condition with a good outcome.

Discussion

Difficulty in swallowing (dysphagia) is classified into mechanical and neuromotor causes with varied etiologies [1,2]. Dysphagia can rarely be caused by pancreatic disease and is generally due to extrinsic compression of the esophagus by a pancreatic fluid collection, as reported in several case reports by Obuszko Z and Beggs D, Matsusue E et al., Panackel C et al., Komtong S et al., and Chettupuzha AP et al. [3,4,5,6,7]. Pancreatic cancer can rarely present with dysphagia due to mediastinal extension, as described by Bejiga G [8]. This case is an unusual presentation of pancreatitis of alcoholic etiology with dysphagia due to a collection entering the esophagus intramurally, a pancreatico-esophageal fistula, which was diagnosed by EUS and confirmed by MRI, in contrast to reported cases where dysphagia was due to extrinsic compression by collections, as reviewed by Matsusue E et al. and Bhasin DK et al. [4,9,10]. Disruption of the esophageal wall by a collection has not been reported to date, and therefore, we hereby report such a case and would like to introduce the term "dysphagia pancreatica," which may be an apt term. Conservative management with analgesics and Octreotide helped patient recover initially.

Another episode of pancreatitis led to the complication of a massive left pleural effusion due to a PPF, which has also been described in several reports, including those by Khadka M et al. and Ito H et al. [11,12]. Management of a PPF can be conservative or involve interventions such as endoscopic retrograde cholangiopancreatography (ERCP) with pancreatic sphincterotomy/pancreatic duct stenting and EUS-guided procedures. The patient's temporal profile of events suggests that the pathway for the PPF could be through the esophageal wall, apart from the diaphragmatic hiatus, which has been reported previously [4,10]. Percutaneous drainage of the massive pleural effusion followed by EUS-guided cystogastrostomy helped manage this condition with a good outcome.

Conclusions

This case represents an unusual presentation of pancreatitis with a collection causing dysphagia due to extension of the collection into the esophageal wall, consistent with a pancreatico-esophageal fistula. We could therefore consider the term “dysphagia pancreatica,” as the dysphagia was due to a pancreatic cause. The patient subsequently developed another complication, which was appropriately managed using a multimodal approach, resulting in a favorable outcome.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Viswanath Reddy, Saireddy Yerrolla, Sapna Marda, Lalith Balla

Acquisition, analysis, or interpretation of data: Viswanath Reddy, Lalith Balla

Drafting of the manuscript: Viswanath Reddy, Saireddy Yerrolla, Sapna Marda, Lalith Balla

Critical review of the manuscript for important intellectual content: Viswanath Reddy, Saireddy Yerrolla, Sapna Marda, Lalith Balla

Supervision: Viswanath Reddy

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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