CARDIOSPASM IN THE AGED

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Cardiospasm is as a rule most frequently encountered in youth or middle age. When, however, elderly people begin to show symptoms of interference with deglutition, apparently due to some narrowing of the œsophagus, one is more inclined to consider the condition carcinomatous and without making an exhaustive examination allow these patients to gradually starve, appreciating the fact that radical therapy is of so little effect and that a gastrostomy merely prolongs for a short time a life of suffering.

That this danger of not making a thorough examination is a very pertinent one is illustrated in the recitation of the following two cases:

Case I.—Single, age sixty-one, male, November 7, 1921. Previous to examination had been seen by several competent physicians by whom a diagnosis of carcinoma œsophagi had been made. His first complaint had begun in May, 1918, when he noticed that on bending forward saliva or some secretion flowed back into his mouth. Two months later it was noted that the food passed into the stomach with difficulty, liquids as well as solids, and was in a large measure regurgitated. This occurred also at night. Intensity of his complaint steadily increased.

On examination it was apparent that there was a large retention in the œsophagus which was cleared only after long-continued lavage. Radiographic examination showed a marked dilatation of the œsophagus, ending at the hiatus œsophagi, where it passed into a fine-lined shadow, resembling in all respects that seen in instances of cardiospasm. There was, however, some little doubt as there was a blurring of the termination of the funnel. An ordinary stomach tube did not pass the cardia, but after a thin soft sound had been carefully passed first, a thick stomach sound was passed easily. Subsequently a Gottstein sound was passed easily and withdrawn after being filled with water, demonstrating that we were not dealing with an organic stricture. Œsophagoscopy demonstrated a greatly dilated œsophagus with marked infolding near the cardia, no evidence of tumor was to be seen, even after the œsophagoscope had been passed through the cardia. Diagnosis was therefore made of cardiospasm. His treatment consisted of feeding through a stomach tube and lavage of the œsophagus. The man rapidly familiarized himself with this technic and was able to carry it out himself without difficulty, gradually taking food by mouth until within a short time he was able to eat with comfort.

On examination, June, 1922, he appeared in perfect health and had since April, taken all of his meals normally, but was careful to have the food in a fine state of division. The œsophagus apparently emptied itself completely. His weight had increased 3½ kg. Final radiological examination shows a practically perfect recovery of the function of the œsophagus. There remains a moderate degree of dilatation which, however, is greatly reduced.

Case II.—Female, age sixty-six. Complained of difficulty in swallowing for more than a year of varying degrees, but lately very little food has passed into the stomach and patient has been rapidly failing.

The examination showed practically the same findings as noted in the previous case with, however, the difference that we were not able to pass the cardia with the œsophagoscope and only succeeded in getting into the stomach with the stomach tube after preliminary sounding with a thin malleable sound. Later we were able to dispense with this preliminary sounding. The slow progress of the illness justified our inferences that the case was certainly one of cardiospasm. During the course of her treatment she developed a peritonitis which, however, was not caused by perforation of the œsophagus, and on laparotomy examination of the cardia and stomach did not show the presence of any tumor. It was noted that the intra-abdominal part of the œsophagus was very long, as occurs so frequently in cases of cardiospasm. While the general condition of the patient has improved greatly under this treatment, all evidence being to the effect that we were dealing with cardiospasm. Trial omission of the stomach tube feeding has not as yet been made, and we have not been able to judge of the functional recovery of the œsophagus.

While as stated previously, the greater percentage of instances of cardiospasm have been observed in middle-aged patients, here we find two cases in whom the condition has occurred, one at the age of fifty-eight, and the other at the age of sixty-five, therefore one should be careful not to make a diagnosis of carcinoma of the œsophagus, however probable it may be, merely on account of the age of the patient and allow the patient to suffer unnecessarily from the lack of treatment which will make them entirely comfortable.

The first case shows how completely recovery can be obtained in a case of cardiospasm from stomach tube feeding and the ultimate restoration of the œsophagus obtained, as demonstrated radiologically. This case apparently negates the argument that cardiospasm follows a primary mega-œsophagus as promulgated by Von Hacker and Sencert.

However, this simple treatment is not always so effective as in the case quoted as noted in a previous communication,[1] in which such treatment was entirely ineffectual during two and one-half years, while subsequent operation by Heller led to a very considerable lasting improvement with practically recovery of the case. However, the treatment of lavage of the œsophagus and stomach tube feeding is so simple that this class of case should be given a thorough trial with it first. Operative intervention is naturally of a more serious character and even the dilatation treatment with the Gottstein sound is not without its dangers. Cases in which this has been used have suffered from perforation with subsequent death.[3] Plummer and Porter report seventy-five per cent. of 301 cases relieved by divulsion, obtained by means of a hydrostatic dilator with pressure of thirty feet of water, although in the beginning of this treatment they lost two patients from rupture of the œsophagus. Naturally, if it is impossible to pass the stomach tube through the cardia, the case cannot be treated as the two cited in this article have been, and one may attempt sounding under the circumstances, passing the sounds under guidance of the œsophagoscope, as recommended by Benjamins in Holland and Guisez in France.

In many of these cases in which at the beginning it was impossible to pass the cardia, it has been possible to eventually accomplish this by beginning with a thin pliable bougie with terminal olive bulb, with which one may in many instances succeed in passing the cardia. This should be followed by increasing the gradated sizes after which the stomach tube may frequently pass with ease, which primarily was impossible.

It is our custom, therefore, to only consider operative intervention as the last resort. The usual method employed in Holland is that of Heller, in which a longitudinal incision is made across the narrowed part and deepened as far as the mucosa. We have now employed it in eight cases without mortality. The results are very satisfactory, although subsequent radiologic examination show that a condition of *restitutio ad integrum* has not been effected. It does not appear to make any difference relative to the subsequent findings whether the incision is made on the anterior side and one on the posterior side as Heller [4] did, or one incision only on the anterior side as has been employed by de Bruine, Groeneveldt and myself. Heller points out that he considers it necessary to lengthen the incision particularly downwards, whereas it need only to be carried upwards as far as the beginning of the dilatation.

REFERENCES

[1] Zaaijer: Cardiospasmus en andere slokdarmaandoenigen, S. C. von Doesburgh, Leiden, 1918.

[2] Acta oto-laryngologica. Vol. ii, Fasc. let. 2, p. 188, 1920.

[3] Plummer and Porter: Med. Clin. of N. America (Mayo Clinic, Nr.). Bd. 5, Nr. 2, pp. 355–369, 1921.

[4] Verhandlungen der Deutschen Gesellschaft fur Chirurgie, 1921. 1. S. 144.