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INTRODUCTION

Iatrogeny accounts for 50-60% of esophageal perforations. Boerhaave's syndrome (BS), a spontaneous perforation resulting from a sudden increase in intraesophageal pressure caused by straining or vomiting, accounts for approximately 10%. Other causes of spontaneous perforation are related with caustic ingestion and esophageal diseases in general. In most cases of BS the tear occurs at the left postero-lateral aspect of the distal esophagus and extends for several centimeters. In about 50% of the cases, clinical presentation mimicks more frequent pathologies. Physical examination is usually not helpful but crepitation, from subcutaneous emphysema, can be an important finding. A pleural effusion may be detected, usually left-sided. Plain chest radiography and water-soluble contrast studies and CT scan should be promptly obtained. Endoscopy has a role but the endoscope itself can extend the perforation and introduce air into the mediastinum.

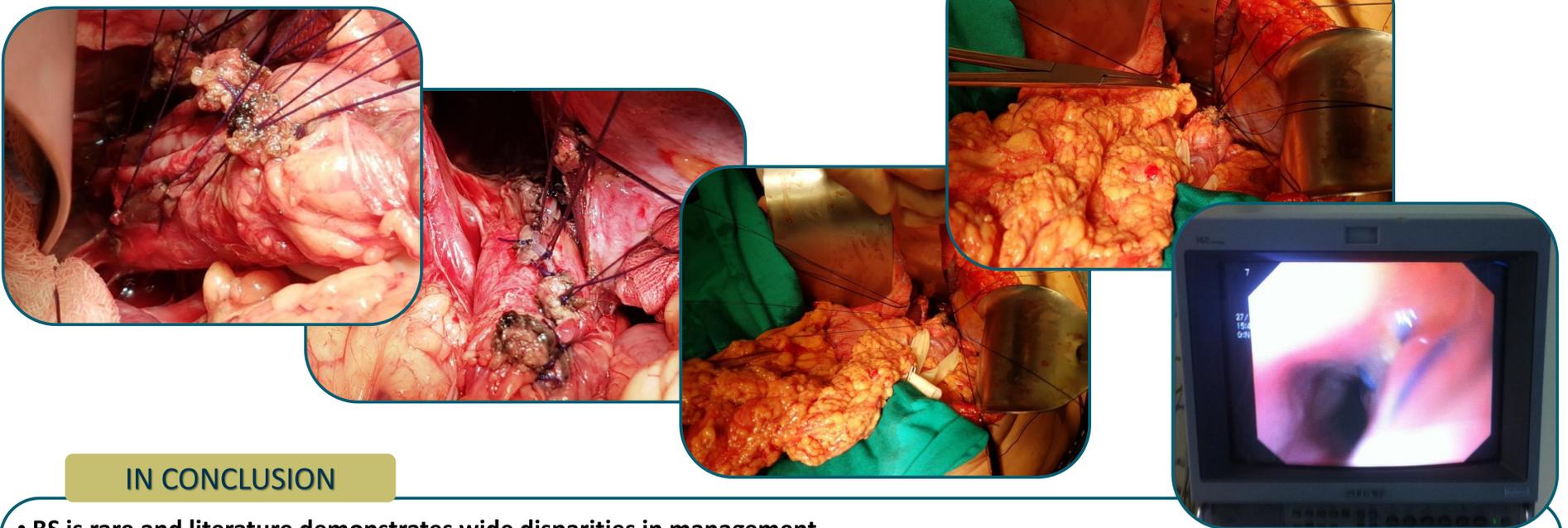
CASE REPORT

- 58-year-old male, septic and in respiratory difficulty, transferred from another hospital.
- Spontaneous perforation of the distal esophagus, about 24 hours of evolution.
- Left pleural effusion. After the introduction of a transthoracic drain on the left, fluid and food debris were withdrawn.



SURGERY

The surgical approach was transabdominal, with median frenotomy (Pinotti). The lack of coincidence between the esophageal rupture, right anterolateral, and the rupture site of the left mediastinal pleura called the attention to a possible double mechanism of injury, with the lesion in the pleura related with a nasogastric tube. After exposure of the esophagus and washing of the mediastinum, we proceeded to the primary repair of the wound and to the preparation of a long flap of omentum to be left in the anterior mediastinum, for protection. A suction drain was left on the left side, near the ruptured pleura. A jejunostomy (Witzel) was left for early feeding. The patient has been discharged home 40 days later.



IN CONCLUSION

- BS is rare and literature demonstrates wide disparities in management.
- Mortality of untreated BS is nearly 100%. Even with early surgery (<24 h), the risk of death is around 25%. With delays (>24 h) it may go up to more than 50%.
- Treatment includes IV fluids, immediate antibiotherapy and surgery.
- Primary repair is appropriate for ruptures diagnosed early. For ruptures diagnosed late, T-tube drainage may be the simplest way to manage the condition.

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