

A Digestive Cause of Respiratory Distress

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Received: 01 July 2024

Accepted: 22 July 2024

Published: 29 July 2024

J Short Name: JCMI

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Citation:

Beaouiss M, A Digestive Cause of Respiratory Distress. J Clin Med Img. 2024; V7(21): 1-2

Keywords:

Respiratory Distress; Esophageal Cancer

A 63-year-old man, a chronic active smoker with a history of solid dysphagia for 4 months, presented with mild hemoptysis for the past 15 days, complicated by respiratory distress, leading to his hospitalization in the emergency department. The patient was polyene with SpO₂ of 85% in ambient air. The X-ray did not show any abnormalities, and the ECG was unremarkable. The investigation revealed elevated D-dimers at 2100. A chest CT angiography to rule out pulmonary embolism did not show any pulmonary embolism. However, it revealed a significant circumferential tissue thickening of the thoracic esophagus extending from D1 to D6, reducing the esophageal lumen which remains patent, measuring 31mm in maximum thickness and extending over 126mm, causing an endotracheal bulge reducing its lumen (**Figure A**). Bronchoscopic examination showed compression of the lower 1/3 of the trachea, which was unable to be catheterized, appearing extrinsic due to the esophageal process described on the CT scan (**Figure B**) Biopsies were performed and returned as moderately differentiated infiltrating squamous cell carcinoma. A PET scan was requested for staging, which revealed intense and diffuse pathological hypermetabolism of the thoracic esophagus from D1 to D6 invading the trachea by 37mm, with lymph nodes in the mediastinum and bilateral hilar pulmonary regions (**Figure C**).



Figure A :CT chest angiography

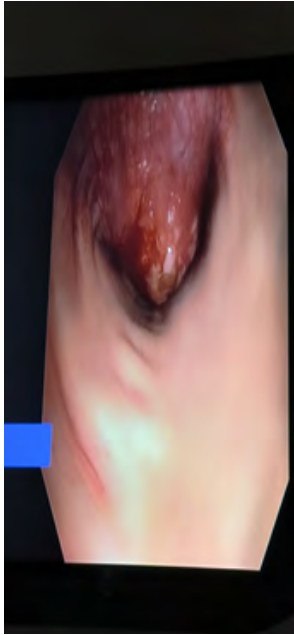


Figure B :Bronchoscopy



Figure C: PET scan