

Gastrointestinal complications and esophageal stenosis after crack cocaine abuse

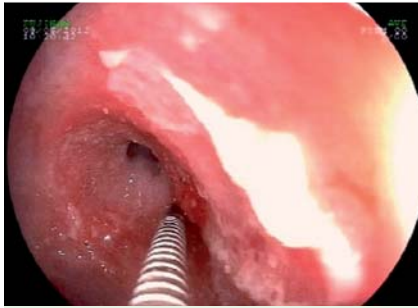


Fig. 1 Upper gastrointestinal endoscopy showing diffuse erythema and mucosal breaks involving more than 75% of esophageal circumference, food stasis and esophageal stricture 30 cm from the superior dental arch. The patient was a 29-year-old man with abdominal pain in whom prior exploratory laparotomy had revealed an ischemic segment of the small bowel and a perforated gastric ulcer next to the prepyloric region.

We describe the case of a 29-year-old man who presented to the emergency room complaining of sudden and severe abdominal pain for 3 days. Evaluation on admission revealed low blood pressure, an increased heart rate, and tachypnea. Abdominal examination revealed a positive Blumberg sign and an abdominal radiograph showed pneumoperitoneum requiring urgent surgical evaluation. In the operating room, the emergent exploratory laparotomy revealed an ischemic segment of the small bowel and a perforated gastric ulcer next to the prepyloric region. Following appropriate surgical management and a favorable course over 17 days in hospital, the patient was discharged.

However, 14 days after discharge, the patient returned due to dysphagia for solid foods and vomiting. An upper gastrointestinal endoscopy (UGE) showed diffuse erythema and mucosal breaks involving more than 75% of the esophageal circumference, food stasis, and an esophageal stricture 30 cm from the superior dental arch (● Fig. 1). An esophageal radiograph showed irregular narrowing of the distal segment of the esophagus over about 13 cm (● Fig. 2). A provisional diagnosis of complicated esophagitis was considered and the patient underwent a 30-day course of a proton pump inhibitor, without improvement. UGE was re-

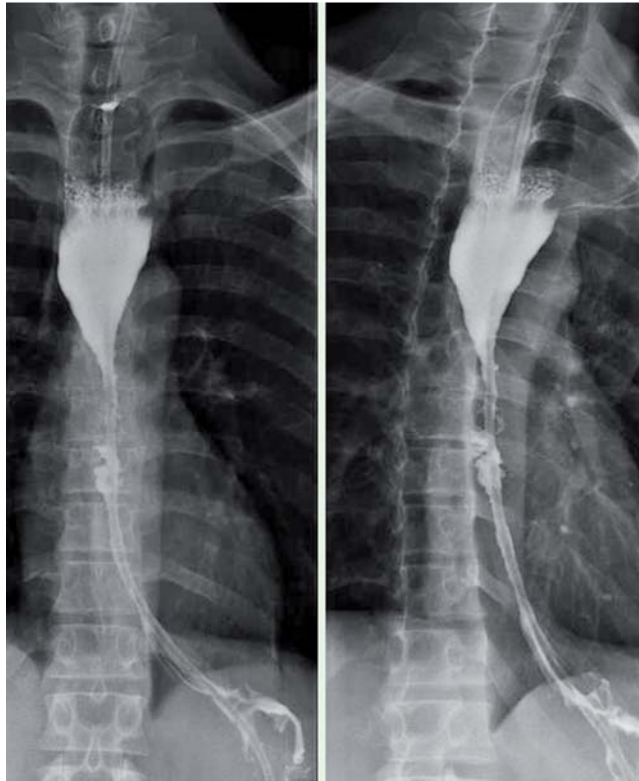


Fig. 2 Upper gastrointestinal tract barium radiograph showing narrowing of and severe injury to the esophagus and stomach.

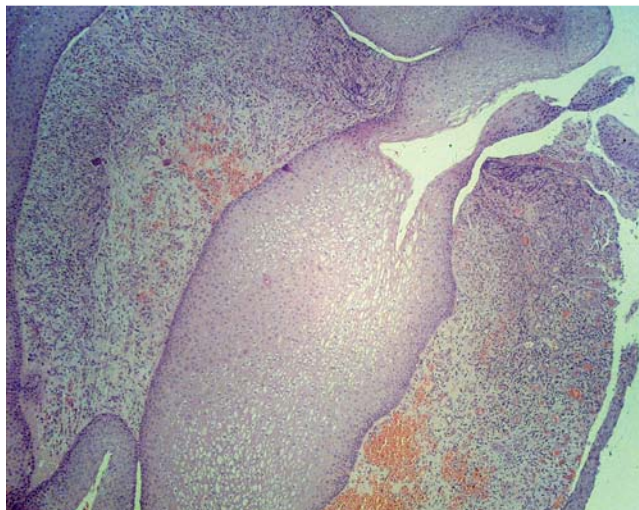


Fig. 3 Esophageal biopsy specimen showing tissue necrosis with intense neutrophilic inflammatory infiltrate, absence of eosinophils, increased papillary height and basal zone thickness (hematoxylin and eosin, magnification $\times 40$).

peated for sampling, and histological examination showed areas of tissue necrosis with intense neutrophilic inflammatory infiltrate, absence of eosinophils, increased papillary height and basal zone thickness, suggesting caustic esophageal injury (● Fig. 3). The patient then admitted using crack cocaine daily over the past 10 years; he used a cheaper mixture

of cocaine, baking soda, gasoline, and glass dust [1]. He also mentioned having a common habit of sucking the plastic wrapper in which the drug was provided, and sometimes swallowing small amounts of crack cocaine. With this last piece of the puzzle in place, a diagnosis of esophageal stricture due to caustic ingestion was established as well as a pre-

sumed correlation with the previous episode of perforation of gastric ulcer and ischemic colitis [2–7]. The patient was reevaluated by a surgical team for definitive treatment.

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Competing interests: None

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