Dysphagia Secondary to Acute Stroke Masquerading as Food Impaction
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INTRODUCTION: Dysphagia is a commonly encountered symptom in gastroenterology, and esophageal food impaction is a common cause of acute onset dysphagia presenting in the emergency room. As such gastroenterologists are often among the first to evaluate patients with a chief complaint of dysphagia. Here, we present a case of acute onset dysphagia concerning for food impaction, where the patient was then noted to have multiple neurologic deficits suggestive of acute stroke.

CASE DESCRIPTION/METHODS: The patient is a 54-year-old male with history of hypertension who presented with acute dysphagia for two hours. His symptom began with lightheadedness, and subsequently developed inability to swallow liquids. His symptoms did not develop acutely after ingestion of any solid foods. He then noted discomfort in his neck, prompting presentation to the emergency department. On arrival, he was hemodynamically stable. Initial labs were unremarkable. Physical exam at time of arrival notable for normal cardiovascular and neurologic exams. Oropharyngeal exam was abbreviated as he was wearing a mask due to the COVID-19 pandemic. GI was consulted for concern for food impaction. While plans were being made for urgent endoscopy, he developed a left facial droop, nystagmus and gait ataxia concerning for acute posterior circulation stroke. He underwent CTA which was notable for occlusion of right vertebral and proximal basilar arteries. He promptly received tPA and was admitted to the stroke service. His neurologic exam improved over the course of his hospitalization and tolerated pureed diet by time of discharge, though with some residual dysphagia.

DISCUSSION: The differential diagnosis for dysphagia is commonly differentiated into oropharyngeal and esophageal pathologies. Within each of these categories, there are both neuromuscular and structural processes which can manifest with symptoms of dysphagia. As gastroenterologists, we are frequently exposed to common esophageal pathologies. However, maintaining a broad differential and avoiding anchoring bias is key for timely recognition of a multitude of diagnoses. Urgent diagnoses which can present with acute onset dysphagia include oropharyngeal infections, acute stroke, and food and/or foreign body impaction. This case highlights the importance of the gastroenterologist, who may be the first person to evaluate a patient with acute onset dysphagia, in maintaining a broad and appropriate differential diagnosis to ensure appropriately and timely treatment of the patient.

A Very Young Barrett’s
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INTRODUCTION: Barrett’s Esophagitis (BE) is defined by the presence of specialized intestinal metaplasia of the gastroesophageal junction. It is typically seen in persons with a chronic history of gastroesophageal reflux disease (GERD). We are presenting a case of an adolescent who was found to have BE with concomitant H pylori infection.

Case Description/Methods: We have a 14-year-old otherwise healthy lady, who presented with worsening chronic abdominal pain associated with recent hematemesis and weight loss. She reports the pain was aggravated by food, without any alleviating factors. She had a normal CT abdomen a month prior to presentation. Three months ago she had an EGD at another facility, and was diagnosed with H. Pylori infection. She completed triple therapy with clarithromycin, followed by retreatment due to persistent symptoms. A thorough laboratory workup was unrevealing including Total plasma porphyrins. An MR enterography was not suggestive of in treatment due to persistent symptoms. A thorough laboratory workup was unrevealing including . Total plasma porphyrins. An MR enterography was not suggestive of inflammation with intestinal metaplasia with goblet cells, consistent with BE without dysplasia. The antral biopsy was consistent with chronic gastritis and positive for H pylori. The patient was discharged on quadruple therapy, i.e. tetracycline, metronidazole, omeprazole, and bismuth subsalicylate and a follow up with gastroenterology.

DISCUSSION: BE is an important risk factor for esophageal adenocarcinoma. BE has an estimated prevalence of 5.6% in the United States and is most commonly seen in Caucasian men. This condition is typically diagnosed in people above the age of 50 years, who often have a history of chronic GERD. Other significant risk factors include central obesity, smoking and a significant family history: BE is exceedingly rare in younger populations and is usually seen in association with esophageal atresia. The findings of BE in our young patient without any of the known risk factors, raises questions regarding our current understanding of the natural history of this condition. Moreover, gastric biopsies were positive for H. pylori infection, which is, in fact, thought to be protective against BE. The risk of adenocarcinoma in patients with BE varies between 0.1-0.4% per year. With an increasing incidence of esophageal adenocarcinoma, there is a need to understand the lesser known variables implicated in the development of BE.