Available online at www.sciencedirect.com

SciVerse ScienceDirect

journal homepage: www.elsevier.com/locate/mjafi

Case Report

Two cases of acute dysphagia

Col R.S. Bhadauria [a,*], Lt Col P.V. Padman [b]

[a] Senior Advisor (ENT), MH, Jabalpur, Madhya Pradesh, India
[b] Classified Specialist (Medicine), MH, Jabalpur, Madhya Pradesh, India

ARTICLE INFO

Article history:
Received 30 October 2010
Accepted 15 December 2011
Available online 14 August 2012

Keywords:
Clostridium tetani
Trismus
Dysphagia

Introduction

Tetanus is rare in the Armed forces today. Therefore diagnosis may be delayed.[1] Fatality is very high in the elderly.[2] The diagnosis is most frequently made on clinical manifestations.[3] In the early stages patients may be termed hysterical or trismus in the elderly may be mistaken for a temporomandibular joint problem.

We report two cases of tetanus in elderly ladies who had unusual presentation with sudden onset of dysphagia.

Case report-I

A 55 years old village lady reported sudden dysphagia to liquids and solids since 1 week. There was no history of pain throat, drug intake, dog bite, trauma, fever, change of voice. She had uterine prolapse since many years and was treated successfully for a swelling in the left groin 20 days back. She was not immunized against tetanus.

On examination her neck muscles were hypertonic and taut but the neck could be flexed. Mouth opening at this juncture was full. Examination of oral cavity and indirect laryngoscopy (IDL) was normal. There was no evidence of palatal palsy and the larynx moved normally in the act of deglutition. Gag reflex was present. The act of deglutition was watched by giving her water to drink. This resulted in drooling out of the water after some time. There was no nasal regurgitation. A Barium swallow done at a previous hospital opined obstruction at level of piriform fossa. However this was ruled out on IDL. A rigid oesophagoscopy was planned to rule out post cricoid growth. A nasogastric tube was passed easily signifying that there was no reason to prevent fluids from going down. Gynaecological examination revealed procidentia with no evidence of decubitus ulcer. Antibiotics were started to cover up for any subclinical infection.

She worsened in the next 2 days, in that she developed trismus and neck stiffness and the characteristic 'Risus Sardonicus' face (Fig. 1). Intermittent abdominal spasms were noted whence stomach contents regurgitated out through the nasogastric feeding tube without any retching or vomiting. Reflexes were brisk and there was stiffness of the proximal muscles of limbs. Planters were flexor. There was no fever or pain and mentation was clear. She had excessive salivation. Systolic blood pressure fluctuated between 90 and 110 mm of mercury. ECG was normal. All lab parameters, CSF and CECT brain were normal. A diagnosis of tetanus was made in view of trismus, dysphagia without a neurological deficit or obstructive lesion, increased reflexes and intermittent hypertonicity of limbs while all other relevant central nervous system disorders were ruled out. The patient was nursed in the ICU. Prophylactic tracheostomy was considered as secretions were very profuse and could initiate a laryngospasm by aspiration. However, the patient positioned herself laterally with head down so that the secretions fell in the kidney tray and she even slept in this position. Instructions were given to insert an

* *Corresponding author.*
E-mail address: sdevrath@yahoo.com (R.S. Bhadauria).

http://dx.doi.org/10.1016/j.mjafi.2011.12.006

Fig. 1 – Risus Sardonicus.

IV cannula through the cricothyroid membrane in the event of a laryngeal spasm. Injection human tetanus immunoglobulin 6000 IU intramuscular was given at various sites. Injections metronidazole 500 mg, piperacillin 4 g, tazobactum 0.5 g, diazepam10 mg IV and tablet baclofen 10 mg eight hourly were also started. Low molecular weight Heparin 40 mg subcutaneously O D was given as prophylaxis against venous thrombosis. Constipation was tackled with enema as glycerine suppository failed. On 10th day of admission she started swallowing saliva and could take a few sips of water (Fig. 2). She complained of a pain, right upper first molar. This was extracted. Mouth opening became full on 15th day. Diazepam and baclofen were gradually discontinued. She started taking normal diet by the 18th day and was discharged on 24th day. Upper GI endoscopy was done before discharging the patient and this was normal. Active immunization against tetanus was also given.

Case report-II

A 70 years old village lady was referred to the surgeon as a case of cervical spondylosis with history of stiffness in the back of the neck and sudden dysphagia to liquids and solids since 4 days. He referred her to the medical specialist to rule out a neurological disorder wherein a provisional diagnosis of hysterical neurosis was made, but she was sent for an evaluation of the throat to rule out any local cause.

There was no history of pain in the throat and no history of trauma, foreign body/food bolus impaction, dog bite or fever. On examination she was alert, normotensive, looking distressed. Voice was normal. There was no cervical lymphadenopathy or tenderness over the cervical spine. Neck muscles were hypertonic and taut so the neck could not be flexed (Fig. 3). Trismus (Fig. 4) was present with mouth opening of two fingers. There was no tenderness at the temporomandibular joints. On IDL through the available gap there was a severe spasm of the jaw muscles and the mirror was caught inside the mouth for a few minutes till the spasm gradually passed off. This immediately aroused the suspicion of tetanus. There was no evidence of dental sepsis. Muscle tone was increased. Deep tendon jerks were brisk and planters were flexor. All laboratory parameters, CSF, and CECT brain were normal. Radiograph of the cervical spine showed mild evidence of spondylitis. Patient was admitted in the ICU.

Human tetanus immunoglobulin 3000 IU intramuscular stat and injection tetanus toxoid were administered at different sites. Injections diazepam and metronidazole were started. Swallowing difficulty improved and neck muscle spasm reduced gradually over the next 2 weeks whence a Barium swallow and upper GI endoscopy were also done but found normal.

Discussion

The diagnosis is relatively easy in areas where tetanus is seen often but is delayed where cases are seen infrequently as in the Armed forces, or when the primary manifestation is other than trismus. Both of our patients had an uncommon presentation as dysphagia. Our first patient was investigated in a previous hospital with a Barium swallow (Fig. 5) which was totally misleading as there was no dynamic obstruction in the oesophagus. The second patient too didn't give an obvious clue except for a mild trismus. A chance spasm when indirect laryngoscopy was being performed was what clinched the diagnosis. Also our patients were villagers and not previously immunized hence tetanus was a high probability.[3]

Trismus, neck stiffness and facial distortion occur early in tetanus as the shortest peripheral nerves are the first to

Fig. 2 – After 10 days of treatment.

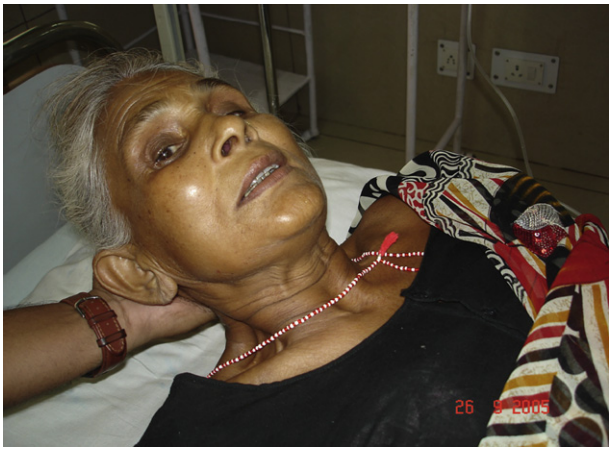

Fig. 3 – Stiff neck, hypertonic muscles.