

LETTERS

Spontaneous intramural esophageal hematoma

Dear Editor,

A 79-year-old woman with arterial hypertension and diabetes mellitus type II, presented with chest pain associated with persistent episodes of hematemesis.

Clinical examination and laboratory tests were normal. In view of the blood-stained vomitus, the patient underwent an upper gastrointestinal endoscopy which revealed a large maroon-colored column extending from 20 cm proximally from the incisors to just beyond the gastroesophageal junction (GEJ), causing partial occlusion of the lumen. A false lumen was also noted (Figures 1A and 1B). Contrast esophagogram was positive for intramural dissection (Figure 1C).

A contrast-enhanced computed tomography (CT) of the chest and upper abdomen revealed an asymmetric mural thickening involving a long segment of the esophagus, extending from approximately T2–T3 vertebral level, up to the T12 level close to the diaphragmatic oesophageal hiatus and extending to the GEJ (Figure 2A).

The patient underwent conservative management (nothing per os, parenteral nutrition, H2 receptor antagonists, antibiotics). Her clinical condition gradually improved. She started oral diet on day 8 and discharged home one week later. A repeat CT scan two months later showed complete resolution of the hematoma (Figure 2B).

Intramural hematoma of the esophagus (IHE) is rare, and patients typically present with chest pain that is difficult to distinguish from other cardiac or thoracic emergencies. Therefore, it is very important for clinicians to be aware of this condition and avoid misdiagnosis¹.

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Keywords: esophagus, hematoma

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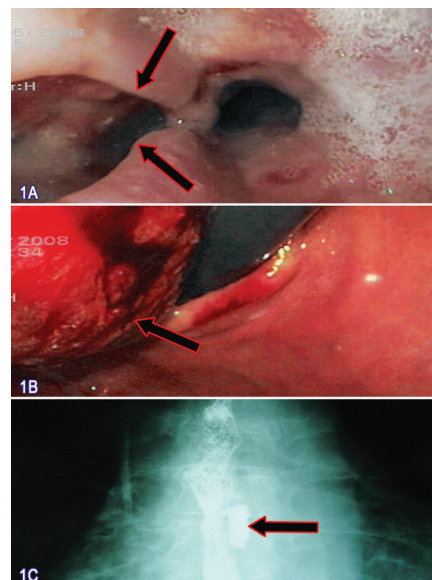


Figure 1: A) Endoscopic view of a large hematoma (arrow) B) False esophageal lumen (arrow). C) Esophagogram revealed contrast material (arrow) inside the wall.

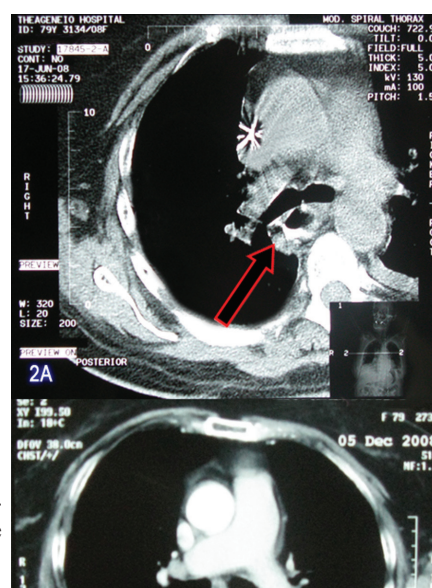


Figure 2: A) Asymmetric mural thickening (arrows) of the esophagus. B) Complete resolution of the hematoma.

Prevalence and sociodemographic correlates of addictive substances use among medical school students

Dear Editor,

We present our study, which aimed at estimating the prevalence of use of addictive substances in a sample of students of Medical school of Aristotle University of Thessaloniki and to assess correlations between substance abuse and the sociodemographic characteristics of this target group.

This descriptive study was conducted in students of first to fifth year of the Medical school (n: 410, males: 185, females: 225, mean age: 20.9 years), using a voluntary, anonymous, self-administered questionnaire. The questions were

not adopted but were developed by the authors based on previous relevant studies¹⁻³. The questionnaire included sociodemographic aspects such as sex, age, current semester, place of origin, residence, financial and family status, parents' level of education as well as information on tobacco and substances (cannabis, benzodiazepines, amphetamines, lsd, ecstasy, syrups, heroin, cocaine) abuse. As a smoker was considered a person who was smoking at least one cigarette daily. Due to the nature of the questionnaire, it was not validated.

T-test for normally distributed data, Man-Whitney test for not normally distributed data and Chi-square tests, were applied to examine associations between substance use and independent variables using SPSS version 12.0 for Windows.

From our sample, 114 students (27.8%) had used at least once one or more illicit drugs (of these 114 students, 19.5% had used cannabis, 9.75% amphetamines, 9.75% lsd, 5.85% inhalants, 5.8% benzodiazepines, 3.65% syrups, 2.7% cocaine, 1.2% ecstasy and 0.7% heroin). They had a higher mean age (Mean=21.55, SD=2.47) than those that had not used any illicit drug (Mean=20.67, SD=1.89), ($p=0.000$). Among them, men ($n=62$, 33.5%) have used more often an illicit drug than women ($n=52$, 23.1%) ($p=0.019$). One hundred and seven students were smokers (26%) and males ($n=60$, 32.4%) were smokers in higher percentage than females ($n=47$, 20.8%, $p=0.009$).

Variables such as residence, place of origin, financial and family status, father's and mother's level of education were not related to the use of illicit drugs. Users of at least one illicit drug ($p=0.011$) and tobacco users ($p=0.013$) report significantly more frequent problematic family relationships and problematic relationships especially with their parents, ($p=0.001$), while tobacco users were more often children of divorced parents or parentless compared to non tobacco users.

The high prevalence of illicit drug use even in students of health professions^{4,5} - who are supposed to be well informed about the consequences of substance abuse - indicates the need to establish prevention programs during medical education which should consider the role of family relationships and mainly the communication of young adults with their parents regardless of parents' education level.

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Key words: drug, substances, abuse, students

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Spontaneous pneumothorax complicating sunitinib therapy

Dear Editor,

A 65-year-old male was diagnosed with a left renal tumor. Whole body CT scanning was negative for metastasis. The patient underwent left nephrectomy and pathological examination was consistent with a renal clear cell carcinoma graded 3 on Furhman scale. He was elected to undergo treatment with sunitinib. Chest CT six months later revealed small nodular formations in the left upper lobe 0.5-1 cm in diameter, enlarged mediastinal lymph nodes and bilateral pleural effusion.

Treatment with sunitinib was continued and two months later, he was admitted with a 5-day history of shortness of breath and pleuritic chest pain. Chest x-ray and CT showed pneumothorax on the left side. Additionally, a cavitation in one of the previously noted lung nodules was revealed and considered as the most probable cause of pneumothorax. A chest tube was placed urgently. Due to persistent air leakage and lung collapse under closed tube, it was decided that the patient was eligible for surgical intervention. He underwent a left mini muscle-sparing thoracotomy. The existence of ruptured bullae on a metastatic lesion was brought to light (Figure 1). Segmentectomy of the left upper lobe was performed. Additional metastasectomies for the other two lesions and a dry gauze abrasion pleurodesis completed the operation. Pathological examination confirmed the presence of metastatic renal carcinoma. One month later, a new chest CT revealed normal findings and sunitinib was restarted.

The suggested mechanisms for chemotherapy-associated pneumothorax include rapid tumor lysis and necrosis of the large metastatic pulmonary lesions, enlargement of a rapidly necrotizing tumor, chemotherapy-induced impairment of repair processes, and/or persistent local infection¹.