An 81-year-old woman was admitted because of bleeding from a transverse colostomy performed 25 years previously for what the family described as "an acute peritonitis."

Symptoms of hypovolemic shock were present on admission (hematocrit, 23 percent), and although emergency explorative surgery was performed, a definite source of bleeding was not found.

Then she entered the intensive care unit, with an irregular pulse rate of 120, blood pressure of 90/60 mm Hg, and hemodynamic failure. A chest roentgenogram was taken at the time (Fig 1); after 24 hours, intense productive cough developed with dyspnea, and another chest film was taken (Fig 2).
Diagnosis: Achalasia secondary to Chagas-Mazza disease.

The first film (Fig 1) showed a dense, nonsegmental image in the right upper lobe. In the second film (Fig 2), that image included an air-fluid level. The presumptive diagnosis was aspiration pneumonia followed by cavitation and spontaneous drainage. Bronchoscopic study showed a lateral deviation of the trachea. When a nasogastric tube was inserted, its progression was blocked at the thoracic level. A barium swallow disclosed complete filling of the previous image and indisputable signs of an enormous thoracic megaesophagus (Fig 3 and 4).

Pulmonary images with gas-liquid content may be ascribed to different etiologies, achalasia being one of the less common. Usually radiologic findings due to achalasia adopt the following patterns: (1) distortion of mediastinal structures; (2) mediastinal neoplasm-like enlargement; (3) gas-liquid image in upper mediastinum; (4) "half moon" image in lower mediastinum; (5) gas-liquid image at neck level; and (6) hyperlucent areas wrongly ascribed to posteroapical neuromata.

A serologic workup for Chagas’ disease confirmed the diagnosis, and further questioning of the patient’s relatives revealed a 30-year history of dysphagia previously unrecognized.

Although in this area of the world 16 percent of the cases of diagnosed megaesophagus are related to Chagas’ disease, this particular radiologic manifestation is nonetheless highly unusual.

Chagas’ disease, the usual name given to American trypanosomiasis, is an infection caused by a protozoan, Trypanosoma cruzi, transmitted to humans by reduviid bugs. This disease is widely distributed in Latin America, where it produces a high morbidity and mortality.

Most patients present with chronic cardiac and gastrointestinal manifestations, the pathogenesis of which is not yet fully understood. It is generally accepted that the leishmanial infestation of the histiocytes adjacent to ganglia produces ganglionic and periganglionic inflammation and later neurolysis. These changes lead to severe denervation of the corresponding gut segment and subsequent megaeosophagus, megacolon, or megaduodenum.

REFERENCES

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