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Dysphagia aortica presenting as esophageal food impaction associated with a large aortic aneurysm: a case report

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ABSTRACT

Background: Dysphagia aortica is a rare form of esophageal dysphagia caused by extrinsic compression of the esophagus by an abnormal thoracic aorta. It is most commonly reported in older patients and can produce marked focal esophageal narrowing.

Case Presentation: A 29-year-old man presented with acute-onset dysphagia, regurgitation, chest discomfort, and inability to tolerate oral intake following ingestion of solid food. Urgent upper gastrointestinal endoscopy revealed an impacted esophageal food bolus, which was successfully removed, resulting in immediate symptomatic improvement. Subsequent endoscopic examination demonstrated marked esophageal luminal narrowing due to apparent extrinsic compression, without an intrinsic obstructing lesion. Contrast-enhanced computed tomography of the chest with three-dimensional vascular reconstruction demonstrated a large saccular lesion described as an aneurysm of the descending thoracic aorta at the level of the carina, measuring approximately 4.8 × 5.3 × 4.7 cm, with mural thrombus and an adjacent hematoma. The aneurysm extended posteriorly behind the esophagus, causing marked esophageal compression, anterior displacement, and proximal dilatation, with no reported active contrast extravasation. Based on the combined endoscopic and radiological findings, dysphagia aortica was diagnosed, with the vascular compression considered the most likely cause of the obstruction. The patient was advised regarding dietary modification and warning symptoms and was promptly referred for vascular surgical assessment and definitive management. The available information did not distinguish a true aneurysm from a pseudoaneurysm or clarify whether the adjacent hematoma represented a contained leak. Subsequent vascular treatment and longer-term outcome were unavailable.

Conclusion: This case highlights an unusual presentation of dysphagia aortica as acute esophageal food bolus impaction in a young adult. Persistent or unexplained extrinsic esophageal narrowing after endoscopic disimpaction should prompt cross-sectional imaging to identify potentially serious mediastinal or vascular causes. The documented outcome was relief of the acute food impaction; the outcome of the underlying vascular disease was unavailable.

Keywords: Dysphagia aortica, thoracic aortic aneurysm, esophageal compression, food bolus impaction, dysphagia, upper gastrointestinal endoscopy.

Type of Article: CASE REPORT **Specialty:** Internal Medicine

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Background

Dysphagia is a common gastrointestinal symptom with a broad differential diagnosis that includes structural lesions, esophageal motility disorders, inflammatory conditions, and extrinsic compression. Although intrinsic esophageal abnormalities account for many cases of mechanical dysphagia, compression by adjacent mediastinal structures should also be considered when endoscopy demonstrates luminal narrowing without an identifiable intraluminal lesion. Among vascular causes, compression of the esophagus by an enlarged, tortuous, or aneurysmal thoracic aorta is an uncommon entity known as dysphagia aortica [1,2].

The term dysphagia aortica was introduced by Pape in 1932 to describe swallowing difficulty caused by external compression of the esophagus by an abnormal aorta [1,3]. The condition has subsequently been associated with thoracic aortic aneurysm, aortic dissection, pseudoaneurysm, and marked aortic tortuosity [1]. Because of its rarity, the true prevalence remains uncertain, and the available evidence consists predominantly of individual case reports and small case series. In a systematic review of 70 reported patients with dysphagia aortica, the mean age was 72 years, and approximately 90% had an underlying aortic aneurysm, pseudoaneurysm, or dissection [1]. Consequently, dysphagia aortica is generally considered a

disorder of older individuals and is particularly unusual in young adults.

Clinical manifestations vary according to the degree and duration of esophageal compression. Patients commonly develop intermittent or progressive dysphagia, particularly to solid foods, and may additionally experience weight loss, chest pain, regurgitation, or respiratory symptoms [1,4]. Severe focal compression can produce marked esophageal narrowing and proximal dilatation, creating an anatomical site at which solid food may become lodged. The present report describes acute food bolus impaction in association with severe aortic compression; it does not establish the frequency or uniqueness of this presentation. Recognition of the underlying vascular abnormality is clinically important because treatment directed solely at the esophageal obstruction does not address the causative lesion, and thoracic aortic aneurysms may be associated with serious complications, including dissection, rupture, and aortoesophageal fistula [1,5].

Diagnosis may require complementary endoscopic and radiological investigations. Upper gastrointestinal endoscopy is particularly valuable when acute food impaction is present because it permits immediate removal of the obstructing bolus and evaluation for intrinsic esophageal disease. However, unexplained extrinsic narrowing or pulsatile compression should prompt cross-sectional imaging. Contrast-enhanced computed tomography (CECT) can define the aortic pathology, demonstrate the relationship between the aneurysm and esophagus, identify associated mural thrombus or surrounding complications, and characterize the extent of esophageal displacement and compression [2,5].

We report an unusual case of dysphagia aortica in a 29-year-old man presenting with acute esophageal food bolus impaction associated with a large saccular descending thoracic aortic lesion described as an aneurysm. The case is notable for the patient's young age, the acute mode of presentation, and the identification of a potentially serious vascular abnormality following endoscopic treatment of food impaction. It highlights the importance of considering extrinsic vascular compression when significant esophageal narrowing persists in the absence of an intrinsic obstructing lesion.

Case Presentation

A 29-year-old man presented to the Haidari Internal Medicine, Gastrointestinal Diseases, Endoscopy, and Colonoscopy Specialty Center with acute-onset dysphagia after ingestion of solid food. He described a sudden sensation of food becoming stuck in the chest, followed by regurgitation and inability to tolerate further oral intake. He also reported chest discomfort but no hematemesis. The presentation was consistent with acute esophageal food bolus impaction, and urgent upper gastrointestinal endoscopy was performed. Vital signs, cardiovascular examination findings, and detailed medical history were not available for this report. Specifically, information concerning hypertension, previous trauma or infection, smoking status, and a family history of aortic or connective-tissue disease was unavailable.

Upper gastrointestinal endoscopy confirmed an impacted food bolus within the esophagus (Figure 1). The food bolus was successfully removed endoscopically, resulting in immediate relief of the acute obstruction and marked improvement in swallowing. After clearance of the bolus, examination revealed significant esophageal luminal narrowing consistent with external compression. No intraluminal mass or other intrinsic mechanical obstructing lesion was identified.

The unexplained extrinsic esophageal narrowing raised concern for an underlying mediastinal process. CECT of the chest was therefore performed after endoscopic disimpaction.

CECT demonstrated a large saccular lesion of the descending thoracic aorta at the level of the carina, described in the available clinical information as an aneurysm measuring approximately 4.8 × 5.3 × 4.7 cm (anteroposterior × transverse × craniocaudal). Mural thrombus and an adjacent hematoma were reported. The lesion extended posteriorly behind the esophagus and caused anterior displacement, marked luminal narrowing, and proximal esophageal dilatation (Figure 2A-C). The thoracic aorta proximal and distal to the lesion was of normal caliber, and no active contrast extravasation was reported. Three-dimensional vascular reconstruction demonstrated the saccular morphology (Figure 2D). A formal radiological classification distinguishing a true aneurysm from a pseudoaneurysm was not available for this report. The adjacent hematoma was not further characterized; therefore, a contained leak or contained rupture could not be excluded from the available information.

The clinical diagnosis was dysphagia aortica associated with a saccular descending thoracic aortic lesion. The severe extrinsic compression was considered the most likely cause of the focal obstruction and food impaction, although no physiological testing results were available to confirm this mechanism.

From a gastroenterological perspective, the immediate therapeutic goals were to relieve the acute obstruction, assess the esophagus for an intrinsic lesion, and determine the cause of the persistent narrowing. These goals were achieved through endoscopic disimpaction followed by CECT identification of the underlying vascular pathology. No additional endoscopic intervention was indicated because the residual narrowing was considered most consistent with external compression rather than an intrinsic esophageal lesion. The documented sequence was presentation, urgent endoscopic disimpaction, subsequent CECT, and prompt vascular referral. Exact dates and intervals between these events were unavailable.

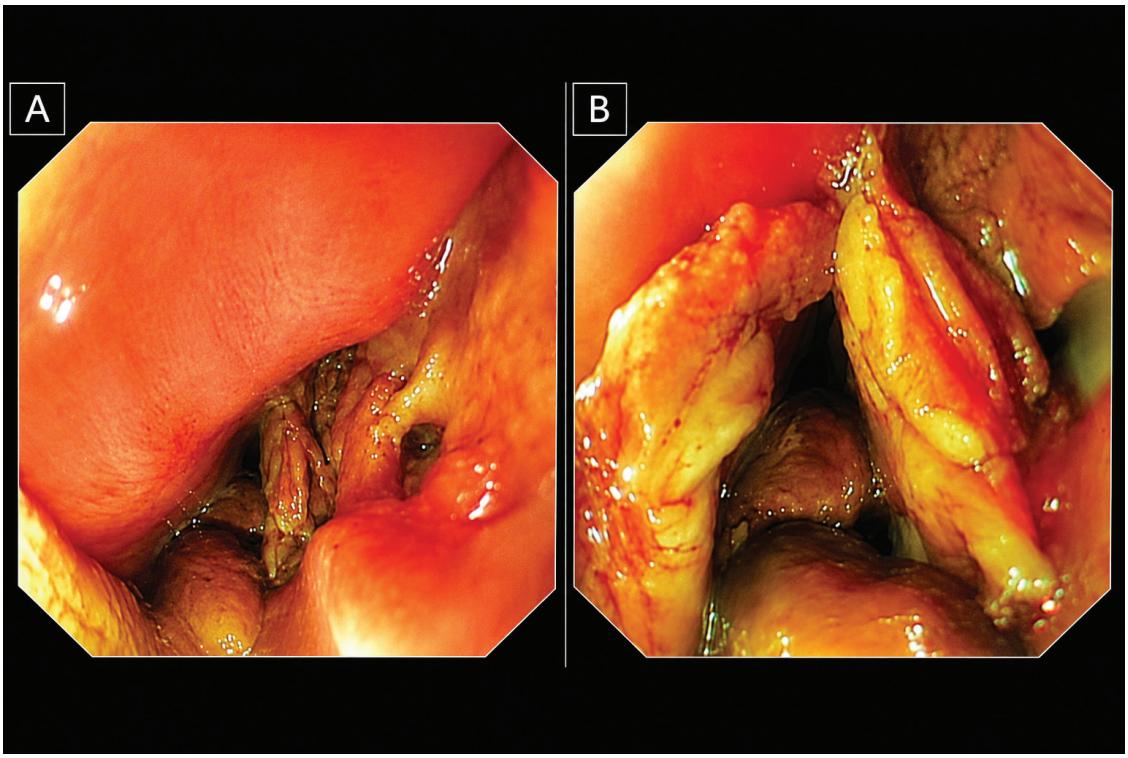


Figure 1. *Upper gastrointestinal endoscopic images obtained during the food impaction episode. (A) Food material within a narrowed esophageal lumen. (B) A second view showing food material and the narrowed lumen.The exact timing of panel B relative to completion of disimpaction was not documented; it is not presented as a confirmed post-disimpaction image.*

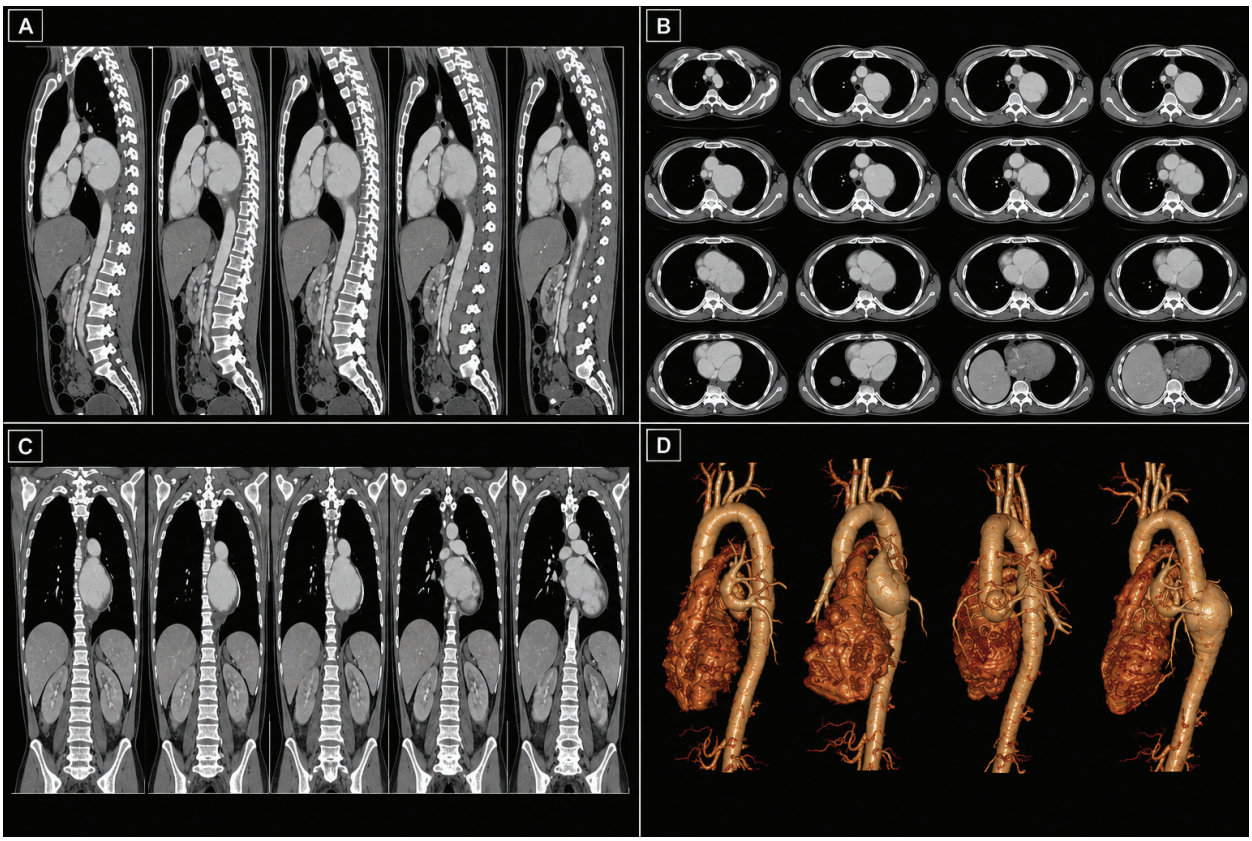


Figure 2. *CECT images of the saccular descending thoracic aortic lesion described as an aneurysm in the available clinical information. (A) Sagittal images showing its relationship with adjacent mediastinal structures. (B) Axial images showing the lesion and associated mass effect. (C) Coronal images showing its location and extent. (D) Three-dimensional vascular reconstruction showing its saccular morphology. Mural thrombus and an adjacent hematoma were reported, but their precise localization could not be verified from the available composite images.*

Because imaging identified a significant thoracic aortic lesion, definitive treatment was beyond the scope of endoscopic therapy. The patient was promptly referred to a vascular surgical team for definitive assessment and management. While awaiting vascular management, he was advised to follow a soft or semi-solid diet, consume small frequent meals, take small bites, chew food thoroughly, and maintain adequate fluid intake during meals. He was advised to avoid large pieces of meat and other dry, hard, or poorly chewed solid foods that could become impacted at the site of esophageal compression.

The patient and his family were counseled regarding the vascular nature of the condition and the risk of recurrent dysphagia or food impaction until definitive treatment of the aneurysm. They were advised to seek immediate medical attention for recurrent inability to swallow, hematemesis, sudden severe chest or back pain, syncope, or any other acute deterioration.

At the time of referral, the acute esophageal food impaction had resolved, and the patient's dysphagia had markedly improved. Information regarding subsequent vascular intervention and long-term outcome was not available to the gastroenterology team. The patient's clinical presentation, diagnostic findings, management, and outcome are summarized in Table 1. Available observation ended at referral, and its exact duration was not documented. Whether attempts were made to obtain subsequent information was also not documented.

Table 1. *Clinical sequence, diagnostic findings, management, and available outcome.*

STAGE	KEY FINDINGS AND MANAGEMENT
Presentation	Acute dysphagia and food impaction in a 29-year-old man; urgent endoscopy followed
Endoscopic disimpaction	Bolus removed; persistent extrinsic narrowing noted
Immediate outcome	Acute obstruction resolved; swallowing improved
Subsequent CECT	4.8 × 5.3 × 4.7-cm saccular descending thoracic aortic lesion described as an aneurysm; mural thrombus and adjacent hematoma reported
Esophageal involvement	Marked compression, anterior displacement, and proximal dilatation
Clinical diagnosis	Dysphagia aortica; vascular compression considered the most likely cause of impaction
Interim GI management	Soft diet, small bites, thorough chewing, and advice about warning symptoms
Vascular referral	Prompt referral after imaging; true aneurysm versus pseudoaneurysm and hematoma significance unresolved
Available observation	Ended at referral; exact event intervals and follow-up duration undocumented; vascular treatment and longer-term outcome unavailable

Discussion

Dysphagia aortica is an uncommon cause of esophageal dysphagia resulting from extrinsic compression by a dilated, tortuous, aneurysmal, or otherwise abnormal thoracic aorta [4]. Because most patients with dysphagia have intrinsic structural abnormalities or motility disorders, a vascular etiology may not initially be suspected. The present case illustrates that dysphagia aortica occurred in a 29-year-old man and manifested acutely as esophageal food bolus impaction in association with severe focal compression.

The age of our patient differs substantially from the demographic pattern reported in the literature. In the systematic review by Grimaldi et al. [1], 70 patients were evaluated, with a mean age of approximately 72 years; approximately 90% had an aortic aneurysm, pseudoaneurysm, or dissection [1]. Dysphagia aortica has traditionally been associated with advanced age, hypertension, aortic atherosclerosis, cardiomegaly, and anatomical changes that increase contact between the aorta and esophagus [6,7]. Mittal et al. [7] described three elderly women with dysphagia resulting from distal esophageal compression by a tortuous nonaneurysmal atherosclerotic aorta. In contrast, our patient was only 29 years old, emphasizing that significant vascular compression should not be excluded solely because of young age.

A particularly relevant comparison is the report by Elsamman et al. [8], who described a 30-year-old man with Behçet disease presenting with rapidly progressive dysphagia. Imaging demonstrated a saccular aneurysm of the descending thoracic aorta complicated by a large para-aortic hematoma producing esophageal compression. This case closely resembles ours with respect to young age, saccular aneurysmal morphology, associated hematoma, and substantial extrinsic esophageal compression. However, our patient presented with acute food bolus impaction, and information concerning investigation for an underlying systemic vascular disorder was unavailable. The occurrence of a significant saccular thoracic aneurysm in such a young patient also highlights the importance of vascular evaluation for an underlying inflammatory, infectious, congenital, traumatic, or connective-tissue-related cause. It is therefore not possible to classify the lesion as idiopathic.

The acute presentation with food bolus impaction is another notable feature. Most published cases describe progressive or intermittent solid-food dysphagia, sometimes associated with weight loss, chest discomfort, or regurgitation [4,6,9]. Wilkinson et al. [6] investigated patients with solid-food dysphagia associated with localized high-pressure zones on esophageal manometry and demonstrated the diagnostic complexity of aortic compression. A previous case also demonstrated hold-up of a solid food bolus at the level of aortic compression during contrast swallow examination [9]. These findings provide

a plausible explanation for our patient's presentation: severe focal extrinsic compression was considered the most likely cause of the obstruction and food impaction. This interpretation is supported by the anatomical relationship, but was not physiologically confirmed.

Upper gastrointestinal endoscopy played both therapeutic and diagnostic roles in our patient. Urgent endoscopy confirmed and successfully removed the food bolus, resulting in immediate relief of the acute obstruction. Importantly, examination after disimpaction demonstrated persistent esophageal narrowing without an intraluminal mass or other intrinsic obstructing lesion. Similar reports have shown that endoscopy may demonstrate extrinsic compression while simultaneously excluding malignancy, peptic stricture, and other intrinsic causes [2,9]. However, endoscopy alone cannot adequately characterize the underlying vascular lesion.

CECT was therefore essential for identifying the vascular abnormality. In our patient, imaging demonstrated a 4.8 × 5.3 × 4.7-cm saccular descending thoracic aortic lesion described as an aneurysm containing mural thrombus and associated with an adjacent hematoma. The aneurysm extended posteriorly behind the esophagus and produced anterior displacement, marked luminal narrowing, and proximal esophageal dilatation. Similar anatomical compression has been reported in patients with thoracic and thoracoabdominal aortic aneurysms [4,8]. Three-dimensional vascular reconstruction in our case further clarified the morphology and anatomical relationship of the aneurysm with adjacent mediastinal structures. The formal radiological classification was unavailable, so a true aneurysm could not be distinguished from a pseudoaneurysm. The reported adjacent hematoma was not further characterized. Although no active contrast extravasation was reported, the available information could not exclude a contained leak or contained rupture, and the hematoma cannot be confidently described as non-active.

No single investigation is regarded as a definitive diagnostic test for all cases of dysphagia aortica. Diagnostic assessment may include endoscopy, barium or videofluoroscopic swallowing studies, CECT, and esophageal manometry [6,7]. Manometry may demonstrate a localized high-pressure zone with vascular pulsations; however, Mittal et al. [7] showed that similar vascular pulsations can occur in individuals without clinically significant dysphagia. In our case, no results of additional physiological testing were available. CECT demonstrated severe anatomical compression corresponding to the endoscopic abnormality, but a coexisting motility disorder could not be excluded.

Another important consideration is the potential for serious complications of aneurysmal disease. Aortoesophageal fistula represents a rare but catastrophic complication of thoracic aortic pathology [5,10]. Consequently, symptoms such as hematemesis, sudden severe chest or back pain, syncope, or hemodynamic deterioration require urgent evaluation. Our patient reported no hematemesis, and no active contrast extravasation was described in the available information; nevertheless, the presence of a saccular aortic lesion, mural thrombus, adjacent hematoma, and substantial esophageal compression justified prompt referral to vascular surgery.

Management of dysphagia aortica depends on symptom severity and the underlying aortic pathology. Patients with mild compression from a tortuous or ectatic aorta may sometimes be treated conservatively with dietary modification and management of cardiovascular risk factors [1,9]. Such measures were used temporarily in our patient while definitive vascular assessment was arranged. However, dietary modification does not constitute definitive treatment for a significant aortic lesion associated with compression.

Treatment of the underlying aneurysm may result in improvement or resolution of dysphagia. Choi et al. [4] described dysphagia caused by a thoracoabdominal aortic aneurysm that resolved following endovascular treatment. Other published experience has similarly demonstrated the importance of correcting the vascular lesion rather than repeatedly treating the compressed esophagus [4,11]. In our patient, further esophageal dilation or other endoscopic treatment was therefore not indicated because the residual narrowing was considered most consistent with external vascular compression. However, the subsequent vascular treatment and its outcome were unavailable; no successful definitive treatment of the aortic lesion can be claimed in this case.

This report has important limitations. Vital signs, cardiovascular examination findings, detailed personal and family history, and information about etiological investigations were unavailable. Exact event intervals and the duration of available observation were not documented. Observation ended at referral, with no information regarding definitive vascular treatment or longer-term outcome; whether attempts were made to obtain subsequent information was also undocumented. The formal radiological classification and interpretation of the adjacent hematoma were unavailable. The timing of Figure 1B relative to completion of disimpaction and the precise localization of the reported thrombus and hematoma in the supplied composite CECT images could not be verified.

Conclusion

Dysphagia aortica is a rare but clinically important cause of esophageal obstruction that should be considered when endoscopy demonstrates unexplained extrinsic esophageal narrowing. This case is particularly unusual because a large saccular descending thoracic aortic lesion was associated with acute esophageal food bolus impaction in a 29-year-old man. Endoscopic disimpaction successfully relieved the acute obstruction, while subsequent CECT

identified the vascular abnormality. This case highlights the complementary roles of endoscopy and cross-sectional imaging in evaluating unexplained esophageal compression. Early recognition is essential because treatment of the esophageal obstruction alone does not address the underlying aortic lesion, which may be associated with potentially life-threatening complications. Patients with aneurysm-related dysphagia should therefore undergo prompt vascular evaluation for definitive management. In this report, success was limited to endoscopic relief of the food impaction and recognition of the vascular abnormality, with the definitive vascular outcome remaining unknown.

Whats new?

This case highlights the unusual presentation of dysphagia aortica in a young adult, manifesting as acute esophageal food bolus impaction rather than typical progressive dysphagia. It emphasizes the importance of recognizing persistent extrinsic esophageal narrowing after endoscopic disimpaction and using cross-sectional imaging to identify potentially serious vascular causes of esophageal obstruction.

List of Abbreviation

CECT Contrast-enhanced computed tomography

Conflict of interest

The author declares no conflicts of interest related to this case report.

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Consent for publication

Written informed consent was obtained from the patient for the publication of his anonymized clinical information, endoscopic findings, and diagnostic images. All personally identifiable information was removed to ensure patient privacy and confidentiality.

Ethical approval

This case report was prepared in accordance with the ethical principles.

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Summary of the case

1	**Patient (gender, age)**	29-year-old male
2	**Final Diagnosis**	Dysphagia aortica secondary to marked extrinsic esophageal compression by a descending thoracic aortic aneurysm
3	**Symptoms**	Acute-onset dysphagia, regurgitation, chest discomfort, and inability to tolerate oral intake
4	**Medications**	No medications reported
5	**Clinical Procedure**	Urgent upper gastrointestinal endoscopy with food bolus removal; contrast-enhanced chest CT with 3D vascular reconstruction
6	**Specialty**	Gastroenterology, vascular surgery, radiology