THYROTOXICOSIS MIMICKING CARCINOMA OF THE OESOPHAGUS

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The classical manifestations of thyrotoxicosis are well known. However, it may also present in many bizarre forms. The gastrointestinal manifestations recorded so far include hyperphagia, anorexia, nausea and vomiting, diarrhoea, steatorrhoea and malabsorption and severe abdominal pain (1, 3, 6). Progressive dysphagia secondary to involvement of the bulbar mucles is a rare symptom and a case is reported here.

CASE REPORT

A 44 year old man presented with progressive dysphagia over a priod of a month. He had difficulty in swallowing solids and eventually could only take porridge and liquids. Food was felt to "stick" at the level of the suprasternal notch. There was associated regurgitation and vomiting of undigested food and he had lost 20 kilograms weight over the preceding three months. He did not complain of heat intolerance, tremors, palpitations or other symptoms of thyrotoxicosis. Besides an episode of epigastric pain two years prior to his present illness, his past history was unremarkable.

On examination he was pale and emaciated. A tachycardia of 110 beats per minute and fine finger tremors were noted. The thyroid gland was moderately and diffusely enlarged and a bruit was present. No proximal or distal myopathy was detected and his cranial nerves were intact. The rest of the examination was normal. A diagnosis of carcinoma of the oesophagus and thyrotoxicosis was made.

The serum thyroxine was 24.9 ug/100 ml, T_3 resin uptake 53.5% and Free Thyroxine Index 13.32. Both barium and endoscopic studies of the upper gastrointestinal tract did not reveal an ulcer, growth or mechanical obstruction of any nature.

The patient was started on Carbimazole 30 mg daily in a single daily dose (7) and his symptoms regressed rapidly. After seven weeks he had gained 14 kg in weight and he had no further complaints of dysphagia or vomiting.

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DISCUSSION

The manifestations of thyrotoxicosis are protean. Although hyperphagia is the hall-mark of thyrotoxicosis, the opposite – anorexia, nausea, and vomiting has also been recorded. This has been termed the "forgotten symptom" by Rosenthal et al (6), and they postulate that it is due to stimulation of the chemical trigger zone centrally by thyroxine. Dysphagia, on the other hand, is probably related to a myopathy affecting the bulbar muscles (4, 5, 2). It is well known that some degree of myopathy is present in most cases of thyrotoxicosis. Classically, the proximal muscles are affected but distal muscle involvement has also been recorded (4, 5). Ophthalmoplegia, when present, is probably related to a different etiology. Although Joasoo (2) suggests that bulbar involvement is relatively common (ten of his twelve cases were seen during a two year period), this is not our experience locally. The cases reported here did not have any clinical evidence of an associated proximal or distal myopathy and in fact mimicked carcinoma of the oesophagus so closely that both a barium study and endoscopy were carried out. It was only when both were negative that the possibility of thyrotoxicosis giving rise to the patient's dysphagia was entertained. His subsequent response to treatment proved that this was indeed the case.

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