**CASE REPORT**

**Mallory-Weiss Syndrome**

Report of a Case Treated Surgically

NORMAN M. SCOTT, Jr., LT. COL. (MC), USA, and DWIGHT E. NEWTON, CAPT. (MC), USAF

Mallory-Weiss Syndrome\(^1,2\)—gastrointestinal hemorrhage from one or more mucosal lacerations in the cardioesophageal region due to vomiting—does not lend itself readily to precise diagnosis, and unless it is specifically looked for, may be missed. In the case to be reported the source of hemorrhage was very nearly overlooked.

A 26-year-old Latin-American male was admitted to Brooke Army Hospital because of hematemesis and melena of two days’ duration. On the day prior to the onset of this illness he had consumed “several beers,” but he was not a chronic alcoholic. The next day he vomited several times, bringing up recently ingested food, and shortly thereafter there was emesis of a small amount of bright red blood and development of vague generalized abdominal distress. He did not vomit again until the next morning when there was emesis of coffee-ground material followed by melena, both of which continued intermittently until admission to the hospital twelve hours later.

A review of this patient’s gastrointestinal background revealed that for eight years he had vomited nearly every morning shortly after arising. Since all of the other members of his family did the same he did not consider this unusual and his attitude was—“doesn’t everybody?”

**Physical Examination**

The patient was short and stocky; his mucous membranes were pale but he was not in acute distress. The blood pressure was 140/80 mm. Hg, pulse 90/min. Palpation of the abdomen revealed it to be soft, nontender, and without masses or visceromegaly; there was no abnormal vascular pattern or spider angiomas present.

**Course in Hospital**

On admission the hemoglobin was 10.2 Gm. per 100 cc. and the hematocrit 32%. Dark clots and fresh blood were observed to return through
Mallory-Weiss Syndrome

a nasogastric tube, and therefore ice-water lavage of the stomach was carried out, followed by esophagoscopy. The esophagus was normal to a level approximately 39 cm. from the upper incisor teeth, that is, just above the normally located esophagogastric junction. At that point visualization was suddenly obscured by the reflux of fresh, dark blood from the stomach; gastroscopy was not attempted. An upper gastrointestinal x-ray series was obtained but was not helpful. The vital signs remained stable, but over the next 24 hours multiple whole-blood transfusions failed to maintain the hemoglobin and hematocrit at satisfactory levels, and it was apparent that hemorrhage was continuing slowly but steadily. Abdominal exploration was therefore undertaken.

It must be confessed that up to this point Mallory-Weiss syndrome had not been considered in this case. However, when inspection of the duodenum and distal stomach failed to reveal any abnormality, and blood was noted flowing from the region of the cardia, a search of that area was made with that diagnosis in mind. A longitudinal laceration 2.5 cm. × 0.5 cm. was found across the posterior wall of the esophagogastric junction. A small vessel could be seen, in its distal angle, from which blood was flowing. By extending the abdominal incision, the laceration was easily sutured and the hemorrhage completely controlled. The postoperative period was uncomplicated and the patient was discharged for home convalescence ten days later. A follow-up gastrointestinal x-ray series was normal three weeks after his operation. The "normal" morning nausea and vomiting have recurred and the patient is being followed in the neuropsychiatric as well as the gastroenterology clinic.

DISCUSSION

This case is considered to be worthwhile reporting because it represents a clinical experience with an unusual—but by no means rare—cause of gastrointestinal bleeding. It affords an opportunity to publicize a condition which surely occurs with greater frequency than is appreciated generally. Decker et al.\(^3\) and Hardy\(^4\) have deplored the scanty recognition accorded the Mallory-Weiss syndrome in the medical literature, pointing out that many large series of cases of gastrointestinal hemorrhage reported from major medical centers fail even to mention it among the various causes listed. Decker et al.\(^3\) reported 11 cases of autopsy-proved Mallory-Weiss syndrome studied at the Mallory Institute of Pathology. They felt that undoubtedly there had been others seen at their hospital, both clinically and at autopsy, in which the diagnosis was overlooked. Chalmers et al.\(^5\) reviewed 101 cases of fatal gastrointestinal hemorrhage and found 3 to be due to this condition. In Palmer’s\(^6\) series