A Case of Spontaneous Esophageo-Pleural Fistula

Mudasir Mir, SKIMS Medical College, Srinagar, India
Aadil Beigh, SKIMS Medical College, Srinagar, India
Arshad Bachh, SKIMS Medical College, Srinagar, India
Mohsin Mushtaq, Dow University of Health Sciences, Karachi, Pakistan
Kunal Bhaskar, SKIMS Medical College, Srinagar, India

ABSTRACT

Spontaneous esophageal-pleural fistula is a rare entity. The authors describe a case of 60-year-old male who presented with cough with expectoration, severe retrosternal chest pain and shortness of breath and vomiting. Computed tomography with oral contrast showed right esophageal-pleural fistula and hydro pneumothorax. He was managed conservatively keeping the chest tube drainage and nasogastric tube feeding.

KEYWORDS

Computed Tomography, Computed Tomography Chest with Oral Contrast, Esophageo-Pleural Fistula, Hydro Pneumothorax

INTRODUCTION

Esophageal-pleural fistula is a rare condition. It occurs secondary to esophageal instrumentation, surgery, malignancy, or as a very rare complication of pneumonectomy (Wechsler, 1986; Wechsler et al., 1982; Liu, Levine, & Torigian, 2006). Spontaneous occurrence of Esophageal-pleural fistula is very rare. Computed tomography (CT) with oral contrast is the very useful imaging technique to diagnose esophagopleural fistula (Wechsler, 1986).
CASE REPORT

A 60-year-old male with a diagnosis of right hydropneumothorax was referred to our hospital with complaint of dislodgement of intercostal tube drainage inserted in their hospital and discharge of pus containing ingested food particles through intercostal tube drainage wound. He presented with cough and expectoration, severe retrosternal chest pain, shortness of breath and copious vomiting for three days. The pain was non-colicky, radiating to back, and there were no aggravating or relieving factors. There was no previous history of the upper gastrointestinal endoscopy or esophageal instrumentation. On coming to our hospital, there was discharge mixed with ingested food particles from the wound site. On respiratory examination, air entry and vocal resonance were decreased on right side basal areas. Patient did not bring chest x-rays taken at first hospital. Chest radiograph (Figure 1), taken at our hospital showed right loculated hydropneumothorax. On drinking a glass of milk, there was oozing of same through the wound which increased after a bout of cough. In order to confirm the esophageo-pleural communication, Computed Tomography of Chest with non-ionic oral contrast (Figure 2) which showed esophageo-pleural fistula in interbronchial and proximal retro cardiac oesophageal segment and circumferential pleural thickening in right pleural cavity. Large pocket of air located in right pleural cavity laterally with fluid and debris with air-fluid level. Contrast was outlining the pleural cavity, accumulating in the paraspinal component of pleura and subsequently tracking into pleural cavity posteriorly with an irregular track, communicating between pleura & esophagus. Right lung showed mild degree of

Figure 1. Chest radiograph
Design Considerations for Delivering E-Learning to Surgical Trainees
[www.igi-global.com/article/design-considerations-delivering-learning-surgical/53818?camid=4v1a](www.igi-global.com/article/design-considerations-delivering-learning-surgical/53818?camid=4v1a)