Case Report

Tubercular Esophageocutaneous fistula- a case report

Meenakshi Kumari[1], Krishna Murari[2*]

[1]Assistant Professor, Department Obstetrics and Gynecology, Mata Gujri Memorial Medical College, Kishanganj, Bihar, INDIA.
[2]Assistant Professor, Department of Surgery, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, INDIA.
Email: drkmurari@gmail.com

Abstract Esophageocutaneous fistula is rare condition characterized by a fistulous connection between esophagus and skin. Tubercular esophageocutaneous fistula is a rare entity and only five cases had been reported. We describe here a case of teenage boy who devloped an oesophageocutaneous fistula which persisted after full course of ATT and ultimately closed surgically with sternocledomastoid, flap.
Keywords: Oesophageocutaneous fistula, sternocleidomastoid flap, endoscopy, bariumsw allow, incision and drainage.

[*]**Address for Correspondence:**
Dr. Krishna Murari, Assistant Professor, Department of Surgery, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, INDIA.
Email: drkmurari@gmail.com
Received Date: 20/09/2015 Revised Date: 12/10/2015 Accepted Date: 03/11/2015

Access this article online

Quick Response Code:

Website: www.statperson.com

DOI: 10 November 2015

INTRODUCTION

India has one of the highest T.B. burden globally accounting for 20% new 8.6 million T.B.cases annually and it is estimated that childhood T.B. consistutes 10-20% of all T.B. cases. Esophageal koch's is extremly rare accounting for only 0.2% of all cases of koch's. Usually it is secondary to an adjacent focus, like lung or mediastenal nodes, spine, larynx or pharynx. involvement of distal esophagus is more common than the proximal one. Esophageocutaneous fistula is very rare complication of esophageal T.B.

CASE REPORT

A 14 year-old boy presented with Oesophageocutaneous fistula from last six years. It started 08 years back as a small pea sized swelling in left lateral side of neck which was painful but there was no induration and it subsided after medication. It recurred after one year at the same site but larger and restricted neck movement. It was diagnosed a cold abscess and treated with incision and drainage and ATT as per DOTS regime for nine months. But the same problem redeveloped after nine months for which again incision and drainage was done. When the wound healed it was noticed a very small pea head sized fistula which was leading to leakage of any liquid taken by mouth. The fistula was low output so it didn't affected his health much and as already number of incision and drainage were done the patient had become quite apprehensive and reluctant for any further surgery. So remained under conservative management from last six years. After much assurance he was ready for surgery. The patient party was wanting definitive cure so they were not ready for treatment with fibrin-glue and Bio-A. He had thin built but no other constitutional and systemic problems. Mild pallor, afebrile TLC, DLC and ESR within normal limit HB- 11.6. All other parameters – within normal limit. X-ray chest normal. Culture for knock's from fistula curetting's- negative. Sputum for AFB- negative. H.I.V and Hbsag was negative. Endoscopy was done but due to old fibrosed condition the opening was barely visible. A fistulogram was done which further confirmed it. After proper preoperative preparation excision of the fistulous track and closure of the wound by giving sternocledomastoid flap was done. Postoperatively patient showed no evidence of any wound complication or collection. A contrast swallow study on 7th day showed no leak following which soft diet was started. Till then he was on ryles tube feeding. He is completely well and eating normally without any leak after one year of surgery. Fistula tract was sent for

How to site this article: Meenakshi Kumari, Krishna Murari. Tubercular Esophageocutaneous fistula- a case report. *International Journal of Recent Trends in Science and Technology* November 2015; 17(1): 118-119 http://www.statperson.com (accessed 16 November 2015).

histopathological examination which was negative for koch's.

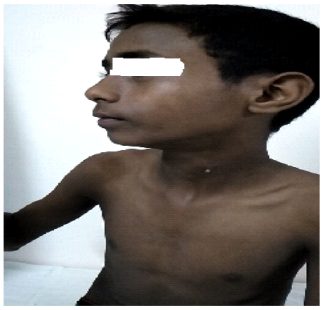

Figure 1

DISCUSSION

Causes of Oesophageocutaneous fistula: Infective, Traumatic, Iatrogenic, Neoplastic Among the infective few cases of oesophageocutaneous fistula are reported with esophageal tuberculosis which is very rare(0.2%) of all Koch's cases. it is generally managed conservatively and usually improves with ATT. **Iatrogenic:** Cases of oesophageocutaneous fistula has been reported after thyroid surgery and anterior cervical spine surgery. Traumatic and post burn fistula had been reported. Treatment varies from case to case. **Fibrin glue and bio**: A are in use for fistula management. But there is risk of serological diseases anaphylactic reaction rejection and multiple sittings may be needed. Stenomastoid flap technique is time tested and suitable for a long standing fistula. To conclude tubercular esophageocutaneous fistula is usually managed conservatively and cures with ATT but the fistula may persist and may need surgical intervention as in the above case. Any abcess in anterior triangle of neck must be treated carefully and thoroughly investigate for koch's.

REFERANCES

1. Pediatric tuberculosis in young children in India; A prospective study; bio med research international vol 2013 article I D 783698
2. Tubercular oesophageocutaneous fistula ;B.N Vinod *et al*
3. Tubercular esophageocutaneous fistula; Rajendra Hajonj *et al*;Indian Journal of surgery 2011 May
4. Post operative pharygeocutaneous fistula; treated by sternomastoid flap repair and cricopharyngeal myotomy; v A Iyoob European spine journal 20012 Sep
5. Product information Tisseel 9fibrin sealant topical)
6. Sathiyasekaran M, Shivbalan S. Esophageal tuberculosis. Indian J Pediatr 2004; 71: 457-8. Shah S. Esophageal tuberculosis: is it so rare? Report of 12 cases and review of the literature. Indian J Gastroenterol 2002; 21: 170.
7. Jain SK, Jain S, Jain M, Yaduvanshi A. Esophageal tuberculosis: is it so rare? Report of 12 cases and review of the literature. Am J Gastroenterol 2002; 97: 287-91.
8. Sharma MP, Bhatia V. Abdominal tuberculosis. Indian J Med Res 2004; 120: 305-15.
9. Esophageocutaneous fistula after ant cervical spine surgery and treatment by sternomastoid flap.

Source of Support: None Declared
Conflict of Interest: None Declared