Case Report

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Rare presentation of TB oesophagus: a case report

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ABSTRACT

This is a rare case report of Tb oesophagus presenting as upper GI bleeding. Patient was subjected to upper gastrointestinal endoscopy, which revealed an ulcerative growth in the mid oesophagus. Biopsy revealed oesophageal tuberculosis. Patient was managed conservatively with Anti-Tuberculosis Treatment (ATT). Follow up endoscopy after six months revealed resolution of the ulcer and patient was symptomatically better. In spite of the rare nature of the disease, it can be managed effectively with ATT to avoid complications (fistula, stricture, and oesophageal perforation), which might warrant surgery.

Keywords: Anti-Tuberculosis Treatment, Biopsy, Gastrointestinal endoscopy, GI bleeding

INTRODUCTION

Oesophageal tuberculosis is rare, constituting about 0.3% of gastrointestinal tuberculosis cases. Involvement of the gastrointestinal tract occurs through ingestion of infected sputum or hematogenous spread from primary pulmonary TB

Most cases of oesophageal tuberculosis are secondary to direct extension from adjacent structures, such as mediastinal lymph nodes or pulmonary sites. Primary oesophageal tuberculosis is even rarer. Oesophageal involvement by tuberculosis usually affects the middle third of the oesophagus at the carina level. Usual presentation is due to dysphagia, retrosternal pain, fever, cough and weight loss. Complications may include hemorrhage from the lesion, development of arterioesophageal fistula, oesophagocutaneous fistula or tracheoesophageal fistula and intramural pseudodiverticulum.^{2,3} There are very few case reports of oesophageal tuberculosis presenting with hematemesis due to oesophageal ulceration.^{4,5}

CASE REPORT

An 18-year-old male presented with c/o hematemesis 2 episodes. H/o loss of weight and appetite present. Clinically vitals stable. Haemoglobin was 11.3 g/dl. ESR was 35 mm first hour.



Figure 1: Ulcer mid oesophagus.

Oesophagogastroduodenoscopy showed Large ulcer mid oesophagus with clot lower end (Figure 1).



Figure 2: CECT chest.

Biopsy was taken from ulcer reported as non necrotising granulomas composed of epitheloid cells and multinucleate Langhan's type of giant cells suggestive of TB. CECT chest: Significant mediastinal lymph nodes which shows calcification and central hypodensity (largest lymph node size 2cm) (Figure 2).



Figure 3: CECT abdomen.

CECT abdomen: multiple celiac and superior mesenteric lymph nodes, the largest of size 12 mm, shows peripheral enhancement with central hypodensity (Figure 3).

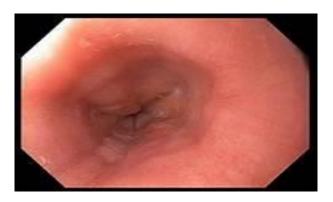


Figure 4: Healed ulcer oesophagus.

Patient was started on a four-drug antitubercular therapy (Rifampicin, Isoniazid, Pyrazinamide, Ethambutol) with marked improvement in his symptoms. Repeat EGD after 6 months showed healing of the ulcer (Figure 4).

DISCUSSION

Tuberculosis of the oesophagus is a rare condition, even in countries with a high incidence of tuberculosis (TB), and studies estimate that it constitutes about 0.3% of gastrointestinal TB cases. 6.7 Involvement of the gastrointestinal tract occurs through ingestion of infected sputum or hematogenous spread from primary pulmonary TB. 8 Most cases of oesophageal tuberculosis are secondary to direct extension from adjacent structures, such as mediastinal lymph nodes or pulmonary sites. Primary oesophageal tuberculosis is even rarer. 9

Oesophageal involvement by tuberculosis usually affects the middle third of the oesophagus at the carina level. ¹⁰ The most common symptoms are dysphagia or retrosternal pain, but odynophagia and weight loss may also be present.

Approximately 65% of the patients with oesophageal tuberculosis have non-specific findings on chest radiograph, however computed tomography of the chest shows characteristic tuberculous lymphadenitis. Clinical, radiological and endoscopic features of oesophageal tuberculosis are not well defined because of its rarity and also its close resemblance with other symptomatic oesophageal disorders.

Oesophageal tuberculosis treatment is based on chemotherapy with four drugs (isoniazid, rifampicin, pyrazinamide and ethambutol) in a first phase lasting for two months, followed by a period of four to six months with two drugs (isoniazid and rifampicin). The two most common differential diagnoses are carcinoma of oesophagus and Crohn's disease of the oesophagus. Surgical treatment is reserved for complications such as perforation, empyema thoracis, oesophageal, tracheo oesophageal and aorto oesophageal fistulas, the latter of which can lead to death by massive hematemesis. Other complications are oesophageal strictures and stenosis.

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