TUBERCULOZĂ ESOFAGIANĂ PRIMARĂ - UN CAZ NEOBIŞNUIT DE DISFAGIE

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Cuvinte cheie

disfagie progresivă, tuberculoză esofagiană

Infecţia TB la nivelul esofagului în absenţa manifestărilor extraesofagiene este extrem de rară. Asocierea între HIV epidemic şi creşterea numărului de cazuri raportate de TBC sistemică a condus la creşterea incidenţei infecţiei la nivelul esofagului în ţările dezvoltate.

Tuberculoza se poate prezenta ca boală primară a esofagului fără manifestări pulmonare. Tuberculoza esofagiană în absenţa infecţiei cu HIV este extrem de rară; debutează cu simptome de esofagită şi disfagie.

Simptomele tuberculozei esofagiene apar în funcţie de gradul şi tipul de afectare. Manifestările pulmonare predomină datorită apariţiei frecvente de fistule spre trahee, bronhii sau spaţiul intrapleural. Uneori disfagia poate apare prin formarea de stricturi sau diverticuli de tracţiune. Deasemenea se poate produce hemoragie digestivă superioară. Aceste manifestări răspund în general la terapia antituberculoasă standard.

Keywords:

progressive dysphagia, esophageal tuberculosis

Primary Esophageal TB - An Unusual Cause Of Dysphagia

Primary esophageal TB in the absence of extra esophageal disease is exceedingly rare. The combination of the AIDS epidemic with the upsurge in reported cases of systemic TB has increased the incidence of esophageal infection in developed countries. In our patient however no cause for immunosuppression was found which makes this a unique case.

TB may present as a primary esophageal disease without pulmonary involvement. Esophageal TB in absence of HIV infection is exceedingly rare. Symptoms of both esophagitis and dysphagia can be seen.

The symptoms of esophageal TB depend on the degree and type of involvement. Pulmonary complaints often predominate because of the common occurrence of fistula to trachea, bronchus, or pleural space. Sometimes, formation of long strictures or traction diverticula causes dysphagia. Upper gastrointestinal hemorrhage has also been reported. The condition usually responds to standard antitubercular therapy.

Learning Objectives:

TB may present as a primary esophageal disease without pulmonary involvement

However primary esophageal TB in the absence of extra esophageal disease is exceedingly rare

Symptoms of both esophagitis and dysphagia can be seen

Case Description:

The patient was a 32 years old female with known CREST syndrome was admitted complaining of one month of low grade fevers, weight loss and one week of dysphagia, progressing from solid food to liquids. She was not on any meds for the last 3 years. She denied worsening polyartralgias or joint stiffness, cough, chest pain, heartburn, melena

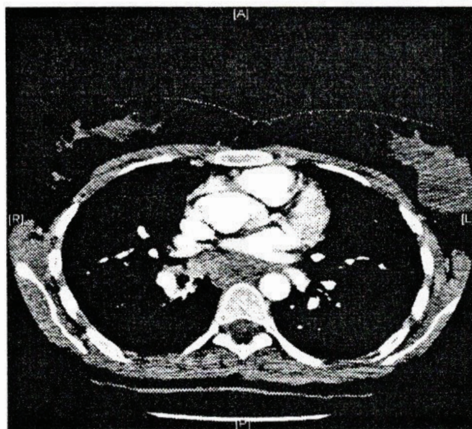
or hematemesis.

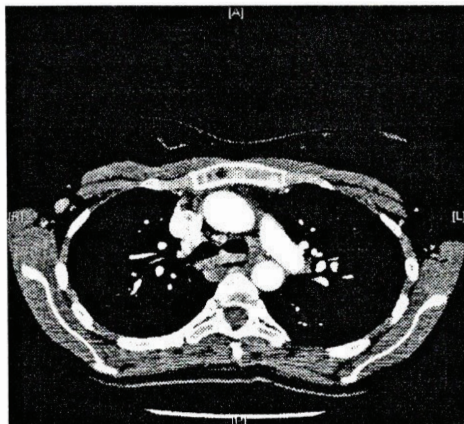
The patient was born in Pakistan and she was living in USA for the last 14 yrs.

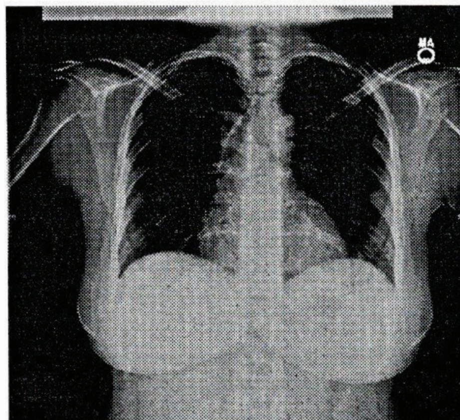
Physical examination was positive only for tightening of the skin of the face and extremities, few teleangiectasias in the face and anterior chest and sclerodactyly.

Routine blood work was in normal limits. Her HIV test was negative.

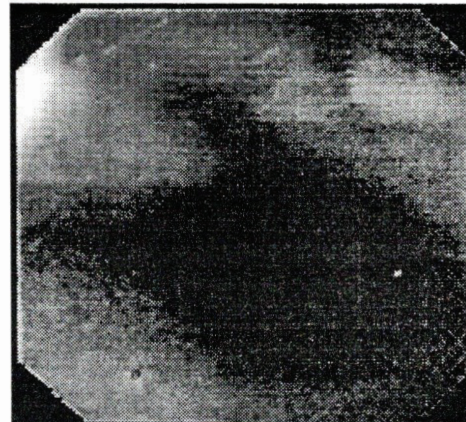
Pt had a CT chest done that showed diffusely thickened esophageal wall, mediastinal lymphadenopathy in the subcarinal region contiguous with the esophagus with a normal lung parenchyma.

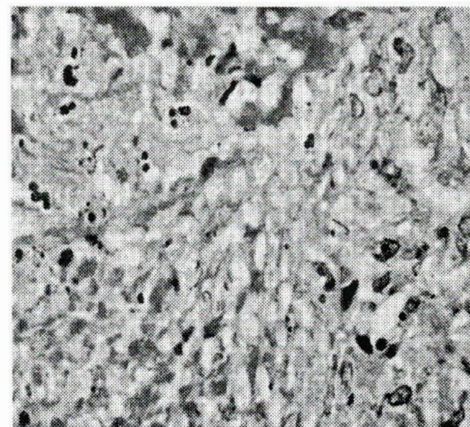






An esophageal stricture due to scleroderma was suspected, so EGD was done and showed a single oval ulcer in the mid esophagus with heaped up edges and necrotic base, which measured 2 cm diameter. The biopsy revealed granulomas with positive AFB staining.





The patient was started on anti tubercular therapy. The cultures from esophageal ulcer came back positive for Mycobacterium tuberculosis that was pansensitive. The sputum AFBs stain and cultures were negative.

Discussions:

Mycobacterial involvement of the esophagus is very rare, even in immunosuppressed patients. The symptoms depend on the degree and type of involvement. Pulmonary complaints often dominate the GI ones because of the common occurrence of fistula to trachea, bronchus or pleural space. Sometimes, formation of long strictures or traction diverticula causes dysphagia. Upper gastrointestinal hemorrhage has also been reported.

TB affects usually the middle 1/3 of the esopha-

gus at the level of carina, being caused by direct extension and spread from mediastinal structures, by inoculation of swallowed sputum as well as by hematogenous or lymphatic spread.

Most patients with primary esophageal TB have underlying mucosal defects, such as Barrett's esophagitis or esophageal cancer.

TB can also involve the upper 1/3 of esophagus by direct extension from tuberculous pharyngitis or laryngitis.

It usually responds to standard antitubercular therapy.

The combination of the AIDS epidemic with the upsurge in reported cases of systemic TB has increased the incidence of esophageal infection in developed countries.

In our patient however no cause for immunosuppression was found which makes this a unique case.

Conclusions:

1. Mycobacterial involvement of the esophagus is rare in both immunocompetent and immunocompromised hosts with advanced pulmonary tuberculosis.
2. TB as a causative factor for dysphagia should be considered in patients from developing countries with high incidences of tuberculosis and in immunocompromised hosts.
3. Diagnosis can be difficult, being based on clinical, radiological, endoscopic, and histological features and on the response to chemotherapy

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