Asymptomatic Spinal Tuberculosis Presenting as Esophageal Stricture

M S BHATNAGAR, SUCHARITA A NANIVADEKAR, PRABHA SAWANT, P M RATHI, A P UPADHYAY

Department of Gastroenterology, LTMG Hospital & LTM Medical College, Bombay 400 022

Abstract

Esophageal tuberculosis is rare and is usually due to secondary extension from contiguous structures. We report a patient who presented with dysphagia and was found to have esophageal stricture. Endoscopic biopsy was not suggestive of malignancy or tuberculosis. CT scan of the thorax revealed involvement of the fourth thoracic vertebra with paratracheal lymphadenopathy. The patient responded to anti-tubercular therapy.


Primary infection of the esophagus by tuberculosis is unusual; esophageal involvement is usually secondary to spread from adjacent structures, eg lymph nodes, spine, lungs, larynx or pharynx, due to hematogenous spread.

A 35-year-old man presented with complaints of retrosternal pain for 6 months and progressive dysphagia to solids for 4 months. There was history of weight loss over this period. The patient had noticed a suprasternal node for 3 weeks, this was initially painless but had become painful one week later. There was no history of fever, cough, anorexia, or hemoptysis. There was no history suggestive of gastro-esophageal reflux disease, acid-peptic disease or corrosive ingestion. Physical examination was non-contributory.

Investigations: Hemogram was normal. Erythrocyte sedimentation rate was 44 mm in the first hour (Westergreen method). Liver function tests, renal function tests, blood sugar, urine analysis and chest X-ray were normal. HIV serology was negative.

Barium swallow showed a smooth narrowing involving the junction of the upper and middle third of the esophagus (Fig 1). Fiberscope endoscopy revealed a smooth narrowing at 22 cm from the incisor teeth with no surrounding nodularity. The endoscope could not be negotiated through the narrowing. Two small polyps were seen above the narrowing. Multiple biopsies and brush cytology examination revealed only squamous cells. Biopsy of the polype revealed inflammatory cells. There was no evidence of malignancy or tuberculosis. The stain for acid-fast bacilli (AFB) was negative. Spuuian for AFB also tested negative on three consecutive occasions.

Fine needle aspiration cytology of the suprasternal node was suggestive of tuberculous lymphadenitis. Barium meal follow-through and barium enema examinations were normal. Abdominal ultrasonography showed no abnormality in the organs and no lymphadenopathy. CT scan of thorax and upper abdomen revealed smooth narrowing of the esophagus (Fig 2), paratracheal lymphadenopathy, and circumferential thickening of the esophageal wall opposite the 4th and 5th thoracic vertebrae. There was surrounding sclerosis and chipping of the anterior facet of the 4th thoracic vertebra. There was no involvement of the bronchus or aorta and no evidence of abdominal lymphadenopathy.

With a presumptive diagnosis of spinal tuberculosis leading to stricture of the esophagus, anti-tubercular therapy (isoniazid, rifampicin and pyrazinamide along with pyridoxine) was started. The dys-
phagia disappeared after 6 weeks of therapy; he gained 3 kg of weight and the suprasternal nodule regressed.

Endoscopic examination and mucosal biopsy have poor sensitivity for diagnosing esophageal tuberculosis. Surgery may be required to clinch the diagnosis in many cases. In the present case the diagnosis was based on biopsy of the suprasternal nodule and CT thorax findings.

A majority of cases respond well to anti-tubercular drugs, but surgery may be required for associated complications such as non-responsive strictures, fistula or abscess formation.

References

NEWS AND NOTICES

First National Seminar on Wilson's Disease and establishment of parent support group will be held on June 23, 1996 at Seth GS Medical College, Parel, Mumbai in collaboration with BARC, Mumbai. Registration fee for doctors Rs. 75 and for postgraduate students Rs 50. Last date for registration: May 31, 1996. For details, contact:
Dr Sunil Karande/Dr Mamta Muranjan
Lecturers, Department of Pediatrics
Seth GS Medical College & KEM Hospital
Parel, Mumbai 400 012

ICMR-NIC Centre has been identified as the agency to disseminate information from MEDLINE and three databases on AIDS to the medical community in the country. To access the MEDLINE databases at NIC, New Delhi an Institution is required to dial up to the nearest NICNET access point using a telephone line or modem. ICMR-NIC Centre (on its own travel cost) may also be invited to present the services available during all conferences/seminars. ICMR-NIC Centre would bear the cost of travel. For clarification and invitation, contact:
Mr S P Rastogi
Project Coordinator, ICMR-NIC Centre,
National Information Centre
A Block, CGO Complex, Lodi Road,
New Delhi 110 033

VI Surgical Gastroenterology Week 'International Update' will be held on September 2-5, 1996 at Department of Surgical Gastroenterology, Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow. Lectures, group discussions, operative workshops, demonstrations and ward rounds by International faculty. Registration fees: (include complete board & lodge for 5 days): private practitioners and/or senior faculty members Rs 5,000, junior faculty level participants (less than 5 years as reader/associate professor/lecturer/assistant professor) Rs 2,500 and post-MS postgraduates in teaching Institutions Rs 1,500. Last date for registration: July 31, 1996. Registration open to a maximum of 50 participants on first-come-first-served basis. For details, please contact:
Prof S P Kaushik
Department of Surgical Gastroenterology,
Sanjay Gandhi Postgraduate Institute of Medical Sciences
Lucknow 226 014
Fax: 91-522-259973
Phone: 0522-440004 to 440008, Ext. 2401

The VI National Conference of Indian Association of Surgical Gastroenterology will be held in New Delhi from September 6-8, 1996. For details, please contact:
Prof T K Chattopadhyay
Secretary, IAGS
Department of Surgery
All India Institute of Medical Sciences
New Delhi 110 029, India

ESOPHAGEAL TUBERCULOSIS – BHATNAGAR ET AL

INDIAN J GASTROENTEROL 1996; 15 (2) 73