When eating becomes a real nightmare

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Mara Sarmento Costa was responsible for data acquisition and editing, manuscript writing and literature revision. Elisa Gravito-Soares, Marta Gravito-Soares, Cláudia Agostinho and Pedro Figueiredo reviewed the literature and manuscript. All authors agreed with the final revision of the manuscript.

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Dear Editor,
We present the case of a 46-year-old female with dysphagia to solids and retrosternal pain that worsened after eating. Due to mediastinal lymphadenopathies, she underwent endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) 3 weeks before, mentioning the complaints started afterwards. On physical examination she had fever (38.3ºC). Gastroscopy revealed three 10-20mm fistulous orifices with purulent discharge at 26-32cm from the incisors and another four partially covered by fibrin in the distal esophagus (Figures 1A/B/C). EBUS-TBNA report was reviewed, mentioning 6 needle passes through the esophagus, due to failed endotracheal intubation, without immediate complications. A cervicothoracic CT scan identified 2 mediastinal abscesses, the largest with 9cm, communicating with the esophageal fistulas. She was admitted, underwent intravenous antibiotics and endoscopy-guided nasogastric tube placement. The histopathological analysis diagnosed Castleman's disease. There was clinical and imagological improvement during admission. After 16 days she was released. Upper endoscopy was repeated one month later showing complete closure of the fistulous orifices.

Discussion
We describe a rare iatrogenic complication of a serious esophago-mediastinal infection post-EBUS-TBNA in a patient with a rare lymphoproliferative disease.\(^1,2,3\) EBUS-TBNA’s infection rate is 0.48%.\(^2\) Castleman’s disease may have contributed as there is an underlying immunologic dysfunction.\(^3\) In difficult endotracheal intubation by EBUS-TBNA, an endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) may represent a safe and effective alternative technique, given the possibility of intraprocedural diagnosis and treatment of complications by directed endoscopic visualization. Additionally, endoscopy poses several treatment options in esophageal fistulas such as endoscopic stenting, so commonly helpful in surgical anastomosis leaks, or even endoluminal vacuum therapy.\(^4\) If stent migration is a concern or happens during follow-up, clipping or the use of suture devices are options to consider.\(^5\) Given the favorable outcome in the presented patient with conservative measures, endoscopic treatment was not performed.
References


Figure 1: Upper endoscopy revealing several esophago-mediastinal fistulas. In the middle third of the esophagus, we were able to identify three fistulous orifices, as shown in Fig. 1A and Fig. 1B, with purulent spontaneous discharge. In the distal
esophagus, shown in Fig. 1C, another four partially covered orifices were identified.