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Esophageal mucocele after surgical isolation of thoracic esophagus presenting with respiratory distress

Surgical management of non-dilatable corrosive strictures of the oesophagus remains a challenge. Surgical resection or bypass of the diseased oesophagus by gastric pull-up or colonic interposition in corrosive injuries has been debated in the literature. While it is always preferable to resect the diseased oesophagus, excision may be technically difficult due to mediastinitis, dense adhesions around the carina, prior perforation or tracheoesophageal fistula.^{1,2} Gastric pull-up may not be possible in cases where stomach is also involved. Surgical isolation of diseased oesophagus with colonic conduit, which is often

performed in these situations, is associated with many early and late postoperative complications.³ This case report illustrates the clinical and radiological findings of oesophageal mucocele which is a rare late postoperative complication.

Case Report

A 28-year-old female presented to the emergency department with history of repeated episodes of fever for one month and history of respiratory distress and orthopnoea for one week. There was history of colonic interposition and oesophageal isolation for corrosive esophageal stricture done two years ago. Clinical examination showed a swelling in the neck at the site of surgery. Contrast-enhanced computed tomography (CECT) scan of the chest done with oral contrast revealed a 5x15 cm sized tubular middle mediastinal cystic structure with thick smooth walls in continuity with the stomach causing anterior displacement and compression of the trachea (**Figure 1**). The stomach was also dilated with diffusely thick walls. There was no oral contrast in the distended oesophagus or stomach. A diagnosis of mucocele of the retained native oesophagus and stomach was made. Since the patient was in respiratory distress, ultrasound guided percutaneous drainage of the gastric component was done immediately and about 400 mL of pus was drained. The patients' symptoms improved and subsequently definitive surgery was done where the dilated native oesophagus and stomach were excised. The post-operative period was uneventful and the patient was discharged in a stable condition.

Discussion

The management of corrosive strictures by surgical isolation of the oesophagus is based on the fact that definitive resection may be unsafe or that the disease may be treated by temporary bypass, with an option of reestablishment of the continuity of the gastrointestinal tract on a later date. Colonic interposition has proved to be the most suitable type of reconstruction for oesophageal corrosive strictures. The choice of the colon

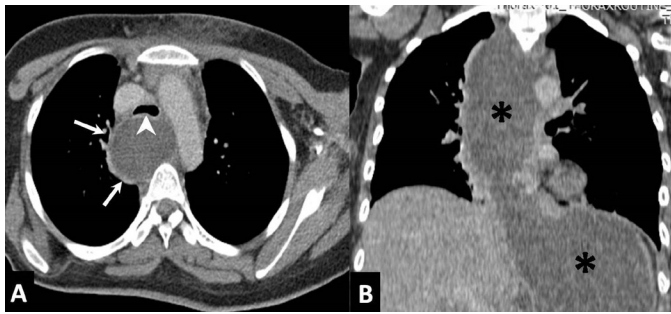


Figure 1: (A) Axial image of contrast enhanced CT scan shows a middle mediastinal cystic structure (arrows) compressing the trachea (arrow head). (B) Coronal reconstruction of the same shows the extent of oesophageal mucocoele, involving the stomach (asterisks).

graft is based on the pattern of blood supply, while the type of anastomosis is determined by the stricture level and the part of colon used for reconstruction.³ The most important early postoperative complication is a cervical anastomotic leakage. Satisfactory long-term results following oesophageal exclusion for corrosive injuries has been reported.³

Oesophageal mucocoele is a rare post-operative complication. Usually, the oesophageal mucosa is almost completely destroyed by recurrent chronic inflammation and scarring and this probably accounts for the rarity of the condition.⁴ The mucous glands may also atrophy due to high intraluminal pressure, and hence the mucocoele fails to attain substantial size.⁴ It usually occurs within two months after surgery, although, there are reports of presentation as late as 10 years.⁵ Most of the mucocoeles remain small and asymptomatic. When symptomatic, they present with chest pain, dysphagia and / or abdominal pain. Respiratory distress, although extremely rare, may be seen in patients with larger lesions, as was seen in this case. Secondary infection of the mucocoele may occur which may result in fistula formation or septicaemia.

The definitive treatment of a symptomatic oesophageal mucocoele is transthoracic oesophagostomy.⁴ There are reports that describe CT-guided percutaneous drainage or tube drainage through thoracotomy as a temporary procedure.⁵

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