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Prevertebral tubercular abscess diagnosed by endoscopic ultrasound-guided fine needle aspiration

Endoscopic ultrasound (EUS) is an excellent investigational modality for evaluation of various mediastinal pathologies.^{1,2} It is perhaps the most sensitive method for the diagnosis of posterior mediastinal lesions and lymph nodes.³ However, complete mediastinal evaluation is not possible with EUS because of its limited ability to visualise the anterior mediastinum because of the presence of the trachea and bronchi anteriorly.

Case Report

A 38-year old male patient was referred to us for evaluation of ascites of two months' duration. He had a history of significant alcohol consumption and an ultrasound

abdomen revealed ascites along with an enlarged liver with an irregular outline and intra abdominal collaterals. There were no varices on gastroscopy and contrast enhanced computed tomography (CECT) of abdomen revealed findings similar to that of ultrasound. Ascitic fluid analysis revealed a high gradient ascites with a high adenosine deaminase value (108 IU/l) and absence of malignant cells. He was started on diuretics and anti tubercular therapy (ATT). However, he continued to require repeated therapeutic paracentesis. Endoscopic ultrasound (EUS) was done to look for peritoneal deposits but none could be identified in the upper peritoneum. A few enlarged celiac lymph nodes were identified and fine needle aspiration (FNA) cytology revealed reactive lymphoid hyperplasia. No significantly enlarged mediastinal lymph nodes were seen but a small pre vertebral abscess was identified in the upper mediastinum (**Figure1**). An EUS-guided FNA yielded cheesy white material (**Figure2**) and a cytological examination revealed epithelioid cell granulomas in a background of extensive necrosis with the presence of acid fast bacilli (**Figure3**). Magnetic Resonance Imaging of the thoracic spine revealed an altered marrow signal involving the body of the third and fourth thoracic vertebra with a pre-vertebral collection showing heterogeneous enhancement on contrast (**Figure4**). He was continued on ATT and diuretics and did not require further paracentesis after completion of three weeks of treatment.

Discussion

EUS FNA is an excellent diagnostic modality for the evaluation of posterior mediastinal lymph nodes as well as soft tissue lesions.¹⁻³ Various studies have demonstrated the safety and efficacy of EUS FNA in these diseases. Diseases involving the anterior vertebral space and vertebrae in the mediastinum can be potentially diagnosed by EUS because of the close relation of these structures with the esophagus. However, there are only few reports of diagnosis of various vertebral pathologies by EUS. There have been reports of diagnosis of anterior vertebral osteophytes by EUS but the diagnosis of pre-vertebral tubercular abscess by EUS-guided aspiration has not been previously reported.^{4,5}

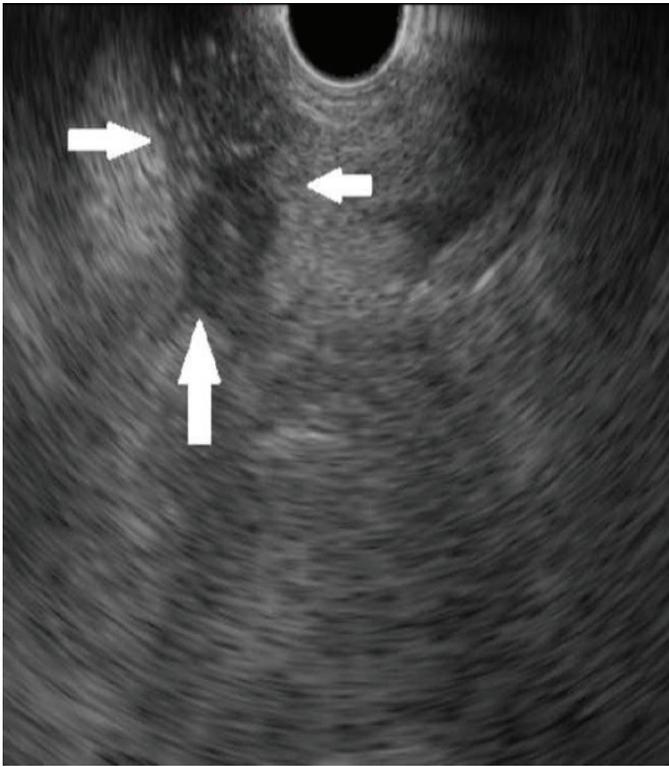


Figure 1: EUS: Pre vertebral abscess with echogenic contents (arrow).



Figure2: EUS guided FNA of pre vertebral abscess.

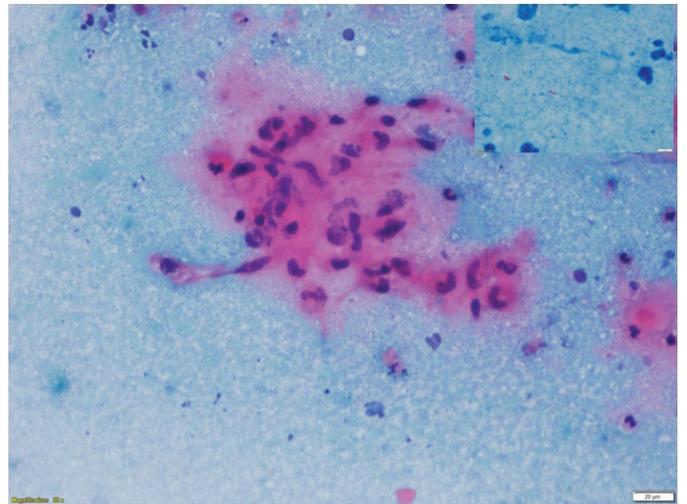


Figure3: Epithelioid cell granulomas in a background of extensive necrosis. (Hematoxylin and Eosin stain 20 X). Inset: Acid Fast Bacilli (ZiehlNeelsen stain 100X)



Figure4: MRI thoracic spine: T1W images showing reduced disc space with altered marrow signal involving D3 and D4 vertebral body with a pre vertebral collection.

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A rare cause of upper gastrointestinal bleed

“Downhill” esophageal varices is a rare condition, first reported in 1964 by Felson and Lessure.¹ These varices have been reported in association with obstruction of superior vena cava(SVC) or its tributaries, secondary to extrinsic compression or thrombosis. Very rarely the SVC obstruction has been reported in mediastinal fibrosis.^{2,3} We present a case of acute upper gastrointestinal bleeding in an individual with fibrosing mediastinitis and past history of intake of anti-tubercular therapy for pulmonary tuberculosis and history of active alcohol intake.

Case Report

A 42-year-old man presented with the history of a single episode, single bout of hematemesis and melena. No history of postural symptoms such as dizziness, presyncope and syncope was reported. He denied any abdominal pain or previous episodes of gastrointestinal bleeding. He also denied painkiller intake. His medical history included past history of anti-tubercular therapy for pulmonary tuberculosis 13 years back.

Physical examination of the patient revealed stable vitals. His abdominal examination was normal with no distension or tenderness. The remaining systemic examination was within normal limits. Initial laboratory tests revealed hemoglobin of 11 grams/dl with normal platelet count and coagulation profile. His renal and liver chemistries were within normal limits.

After adequate resuscitation, an esophago gastroduodenoscopy was performed. Endoscopy revealed grade III esophageal varices with red colour sign (RCS) (**Figure 1**) along the entire length of the esophagus. No active bleeding was noted from esophageal varices at the time of the procedure. However, altered blood was noted in the stomach. His duodenum was grossly normal and no other bleeding lesions were found either in the stomach or in the duodenum. In view of large varices with history of recent bleeding, endoscopic band ligation (EBL) was performed and three EBL – bands were applied.