Painful dysphagia in a case of mediastinal tuberculous lymphadenopathy

M.P. Ghimire and R.J. Walker

Gastrointestinal Unit, Walton Hospital, Liverpool L9 1AE, UK.

Summary: A patient with mediastinal tuberculous lymphadenopathy is described. Presentation was with rapid onset of painful dysphagia following trauma to the neck. Early diagnosis was achieved by mediastinoscopy.

Introduction

In the developed countries tuberculous lymphadenopathy has become uncommon. Most of the cases now seen in Britain are in the immigrant population, especially from the Indian subcontinent. The diagnosis may be missed, particularly when the presenting features are atypical. We describe here a case of mediastinal tuberculous lymphadenopathy presenting with rapid onset of pain and difficulty in swallowing.

Case report

A 34 year old male physician from Nepal had resided in Britain for five years. Symptoms began a week before admission to the hospital.

He fell and banged the front of his neck on the edge of a bath. On the following day he felt pain behind the upper manubrium on swallowing food and drinks. Food tended to stick, but went down with slight increase of effort. This continued and on the second day of illness was accompanied by shivering. Thereafter he developed continuous dragging discomfort in the right upper chest, worsened by swallowing and sudden movements. From the fourth day he developed chills and fever in the evenings and at night. On the fifth day a chest X-ray showed a lobulated mass in the right upper mediastinum. His general health had previously been good and there had been no loss of weight or appetite. The only past illnesses of note were two episodes of ulcerative proctitis lasting a few months about 5y previously.

In 1973 the patient had worked as a resident doctor in a TB sanatorium for about a year. His Mantoux status then was strongly positive.

On examination he appeared unwell with a low grade fever ranging from 37.4°C to 38°C.

The erythrocyte sedimentation rate was raised at 68 mm/h. Mediastinal tomography showed a mass in the right paratracheal region. Barium swallow showed that the upper oesophagus was displaced to the left but not narrowed by the mass.

On the day following admission the patient underwent bronchoscopy, oesophagoscopy and mediastinoscopy. Bronchoscopy showed only slight hyperaemia of the right upper lateral wall of the trachea. Oesophagoscopy showed normal oesophageal mucosa up to the gastro-oesophageal junction and no obvious compression of the upper oesophagus. Mediastinoscopy showed a mass firmly adherent to the upper right lateral side of the trachea. Biopsy was attempted, but was made very difficult by the extensive fibrosis around the mass. Needle aspiration of the mass produced about 30 ml of thick pus. Cytology revealed no malignant cells but polymorphs and lymphocytes.

The pain and difficulty in swallowing settled after the procedure. A clinical diagnosis of tuberculous lymphadenopathy was made and chemotherapy with rifampicin, isoniazid and ethambutol was started. Mycobacterium tuberculosis was isolated on culture of the pus after 3 weeks. The patient became completely asymptomatic within 2 weeks and the mediastinal mass was almost completely resolved 4 months later.

Discussion

This report indicates that mediastinal tuberculosis may occasionally present with oesophageal symptoms. This is rare (Amorosa et al., 1978) and previous reports suggest that pain and difficulty in swallowing are usually due to direct oesophageal involvement (Fahmy et al., 1969; Wales et al., 1976). Recently, 17
cases of surgically proved mediastinal tuberculous lymphadenopathy were reported from China (Xu et al., 1981) and out of these, four cases had dysphagia. However, it is not clear whether any attempt was made in these cases to rule out oesophageal lesions by oesophagoscopy. In our patient there was no overt involvement of the oesophagus and on barium radiology only minor displacement of the oesophagus was evident. We assume that the contiguous inflammation of paraoesophageal tissues resulted in disturbed oesophageal motility.

Our case was not a primary infection and therefore we assume that the nodal involvement had been present for some time and that the trauma to the neck induced reactivation of a previously dormant focus.

Acknowledgements

Our thanks are due to Dr M. Ng for translating one of the reference articles from the Chinese to the English language and also to Miss M. Ward for her assistance in preparing this case report. We are grateful to Mr Soorae who performed the mediastinoscopy.

References
