SAJS
Letter to the Editor

Oesophago-pleuro-cutaneous fistula in an HIV-positive patient

To the Editor: A 53-year-old man who had been on antiretroviral treatment for 8 months presented with dyspnoea, weight loss and night sweats. Investigations showed anaemia (haemoglobin concentration 8 g/dl), leucocytosis (white cell count 20×10^9/l) and dehydration, the erythrocyte sedimentation rate was 135 mm/h, and the CD4 count was 4 cells/µl. The chest radiograph was not suggestive of tuberculosis (TB), but showed a right pleural effusion; a drain was inserted and 1.5 litres of pus was drained. When the drain was removed, ingested food was seen to be draining through the site. Despite this, the patient was in a stable condition. A barium swallow examination confirmed the presence of the fistula, which was also seen on endoscopy, with normal surrounding mucosa (Figs 1 and 2). In order to feed and treat the patient a wide-bore nasogastric tube was placed under anaesthesia. Empirical anti-TB therapy was started, but the patient refused further therapy (feeding gastrostomy followed by operative closure of the fistula) and died at home.

Oesophago-cutaneous fistula due to tuberculosis is very rare, but cases have been reported in HIV-negative patients. Oesophago-pleural fistulas have been reported due to carcinoma, and following pneumonectomy for hydatid disease. In our case it is possible that perforation by a fish bone may have initiated the process of fistualisation.

The differential diagnosis in this case includes histoplasmosis, candida, cancer, trauma, and Crohn's disease. There was no direct evidence that the fistula was a result of HIV infection or related to TB infection. Neither TB nor fungi were cultured; the bacterial pathogens were the usual ones.

HIV and its associated surgical problems are a real challenge for physicians and surgeons. This is the first such case known to us, and no reports of similar cases were found in a Medline search. We suggest that management should be conservative until the CD4 count has improved to a level at which surgery is safe, and stress that the assistance of experienced HIV physicians is essential.

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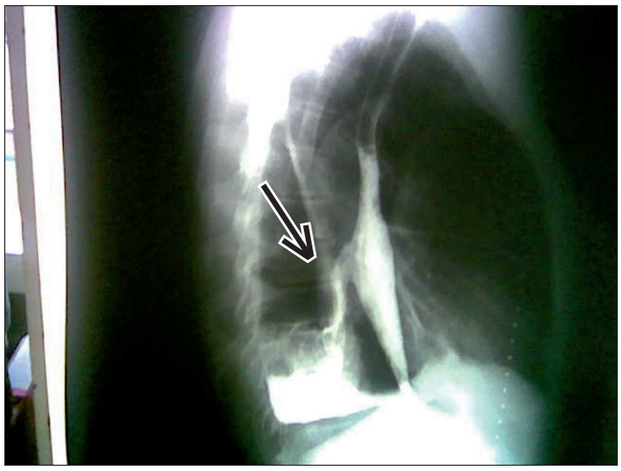

Fig. 1. Arrow indicates fistulous tract on right lateral view.

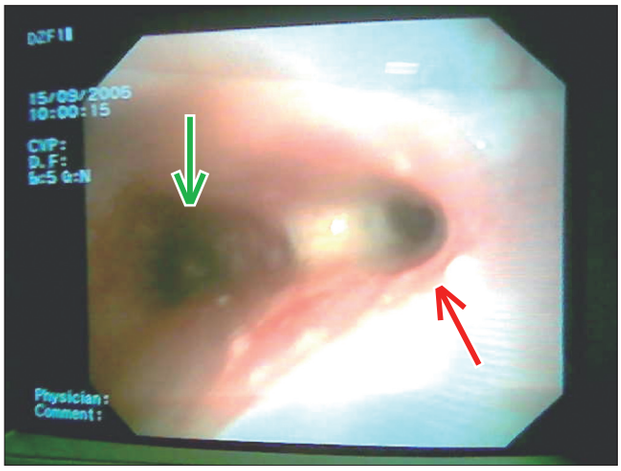

Fig. 2. Red arrow indicates normal oesophageal lumen and green arrow indicates the fistula. Note the calibre is bigger for fistula. Endoscopic view confirms well-epithelialised tract looking macroscopically completely normal. This picture was taken from the endoscopic monitor by a Nokia 6510 mobile phone camera.

REFERENCES

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2. Yokoyama I, Ichihashi H, Kawahara K, Takada M, Kondo T. Esophagopleuro-cutaneous fistula: a case report. *Surgery Today* 1984; 14: 139-142.