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Three Case Reports: Tracheoesophageal Fistulas That Occured Due to Different Reasons

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Introduction: Rarely seen Tracheoesophageal fistula (TEF) is a pathological tract between the trachea and the esophagus. The most common acquired causes are esophageal and lung malignancies. Prolonged intubation, granulomatous mediastinal infections, immunodeficiency syndromes, chest traumas are the other etiologic causes. We present our article as a rare condition because TEF is seen in 3 different patients for 3 different reasons and tuberculosis is a sporadic cause of TEF.

Case Presentation 1: A 78-year-old male patient presented with dyspnea, cough, difficulty in swallowing of solid-liquid foods and heavy sputum. PA chest X-ray revealed a patchy opacity in the lower zones. Oral intake was stopped. CT showed that there was a connection between the posterior of the left main bronchus and esophagus suggesting TEF. During bronchoscopy two large fistula areas were observed at the posterior of the left main bronchus. Tracheal Y stent was placed at the level of the fistula. Mycobacterium tuberculosis was produced in the bronchial aspiration specimen. The patient was diagnosed with TEF secondary to tuberculosis. Anti-tuberculosis treatment was initiated.

Case Presentation 2: A 24-year- old male patient was intubated after substance use and discharged from the intensive care unit with a tracheostomy. The patient presented with fever, fatigue, and cough following food intake. CT showed diffuse consolidation in lower lobes of both lungs and a connective tract area between upper 1/3 proximal of the trachea and esophagus suggesting TEF. Treatment was initiated. Oral intake was stopped. During the bronchoscopy, TEF orifis was seen after the 3rd cartilage of trachea. The place of TEF was not suitable for the stent application or hemoclips application therefore surgery was planned. The patient refused all the offered treatments and was discharged.

Case Presentation 3: A 56-year-old male with squamous cell lung carcinoma was admitted to our clinic in the second month following radiotherapy with complaints of coughing and vomiting shortly after liquid food intake. PA chest X-ray was interpreted as usual. Thorax CT revealed a connective structure between the left main bronchus and the esophagus which was suggesting TEF. The patient was referred to the gastroenterology, and a metallic esophagus stent was inserted by endoscopy. The patient was discharged.

Conclusion: The diagnosis and treatment of TEF are challenging for the clinicians. Aspiration pneumonia can cause serious complications such as sepsis and mediastinitis. The most common cause of TEF is malignancies. In countries where the incidence of tuberculosis is high, tuberculosis should be considered in the etiology of TEF.

Keywords: Tracheosephageal fistula, tuberculosis, postentubation