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Videothoracoscopic Surgery for Acute Bacterial Mediastinitis; A Rare Case

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Introduction: Acute mediastinitis is an uncommon but potentially life threatening infection involving the structures of the mediastinum. Early diagnosis, appropriate antibiotic therapy and surgical intervention may favorably alter the prognosis. We report a 67-year-old man who presented with chest pain and subcutaneous emphysema.

Case Presentation: A 67-year-old man admitted to our clinic with chest pain, fever and general body weakness. Patient's history revealed that his complaints had been present for a week. He had no history of any chronical illness, trauma and surgical intervention. The patient stated that he was swallowed a fishbone 2 weeks ago. Physical examination revealed that the left side of his neck was markedly tender and swollen, without evidence of trauma. His body temperature was 38.2°C. Laboratory analysis showed a white cell count of 17.5_2103/μL and the inflammatory marker C-reactive protein (CRP) was 45 mg/dL. His chest radiogram showed minimally pleural effusion on the left side. Immediate computed tomography (CT) of the chest and neck revealed generalized air bubbles in the mediastinum and left sided pleural effusion. Patient was diagnosed as acute mediastinitis and systemic antibiotic therapy was started. Thoracentesis was applied to the patient and purulent fluid was aspirated from the left side, so chest drainage was planned. To maintain debridement and drainage of the mediastinum right uniportal videothoracoscopy was applied. Purulent contents and necrotic tissues were removed. The pleural space was drained with one chest tube connected to underwater seal. After surgery the patient was followed up for 2 weeks in an intensive care unit but unfortunately died because of pneumonia and sepsis.

Conclusion: The great majority of mediastinal infections are originating from many sources. Most of these infections are related to esophageal disruption. Trauma, tracheobronchial perforation, descending infection following surgery of the head and neck and progressive odontogenic infections are other possible causes. Our patient had no history of any chronical illness, odontogenic infection, trauma and surgical intervention. The history of swallowing a fishbone may explain the occurrence of acute bacterial mediastinitis but we have no evidence for the fishbone perforating the esophagus. There are few cases of mediastinitis as complication of a swallowed fish bone in literature but spontaneous bacterial mediastinitis is extremely rare. Acute bacterial mediastinitis is a life-threatening infection. Early diagnosis and serial transcervical and transthoracic operative drainage and debridement reduce the excessive mortality associated with acute bacterial mediastinitis.

Keywords: Acute mediastinitis, sepsis, videothoracoscopic surgery