

Out of View: A Large Esophageal Ulcer With Fistula to the Spine

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CASE REPORT

A 71-year-old woman with small-cell lung cancer and prior chemoradiation developed upper gastrointestinal bleeding. Urgent esophagogastroduodenoscopy demonstrated a large, cratered distal esophageal ulcer with poor visualization from bleeding that required coil embolization. The biopsied ulcer edges returned negative for malignancy. Repeat esophagogastroduodenoscopy demonstrated a cratered esophageal ulcer with poor visualization from solid debris (Figure 1). Esophagram demonstrated a large ulcer and prevertebral fluid collection with filling of the T9/T10 disk space suggesting a fistula (Figure 2). A computed tomography scan of the thoracic spine (Figure 3) confirmed the fistula and a 3.2 cm prevertebral cavity.

The patient was not a candidate for esophageal stenting or suturing given her prior radiation, lesion size, and inability to externally drain the collection. She was not a candidate for surgery in her current state and died 1 week later.

This is a rare presentation of an esophageal ulcer with fistula to the prevertebral tissues and spine. Acquired esophageal fistulas occur most commonly from malignancy (5%–10% of advanced esophageal cancer); however, other causes include radiation.^{1,2} In patients with concern for a deep esophageal ulcer or fistula, consider further evaluation with an esophagram and/or chest computed tomography scan with oral contrast.

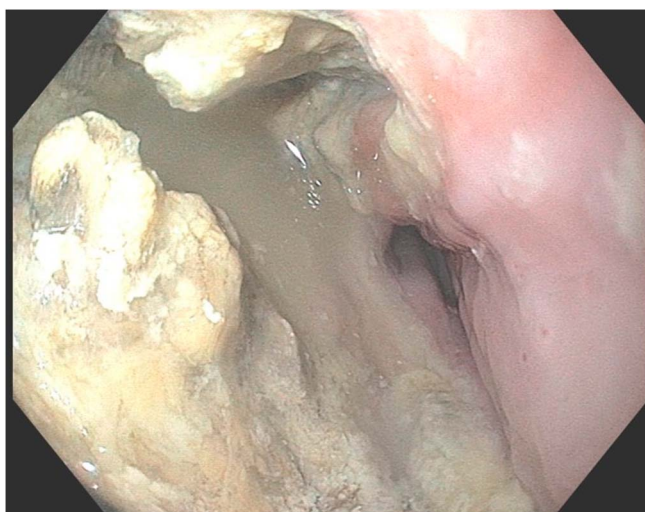


Figure 1. Image of the esophagus during esophagogastroduodenoscopy demonstrating a large, cratered ulcer starting at 33 cm from the incisors measuring 5 cm in length. There was poor visualization because of solid food debris.



Figure 2. Image obtained during fluoroscopic esophagram demonstrating a large distal esophageal ulcer (arrow), corresponding with findings on upper endoscopy, and embolization coils (arrowhead). There was progressive opacification of an adjacent disk space (chevron) suggesting an underlying fistula.

DISCLOSURES

Author contributions: A. Koop wrote and approved the manuscript and is the article guarantor. M. Villalba provided the images, edited the manuscript, and approved the manuscript. JG Hashash edited the manuscript, revised for intellectual content, and approved the final manuscript.

Financial disclosure: None to report.

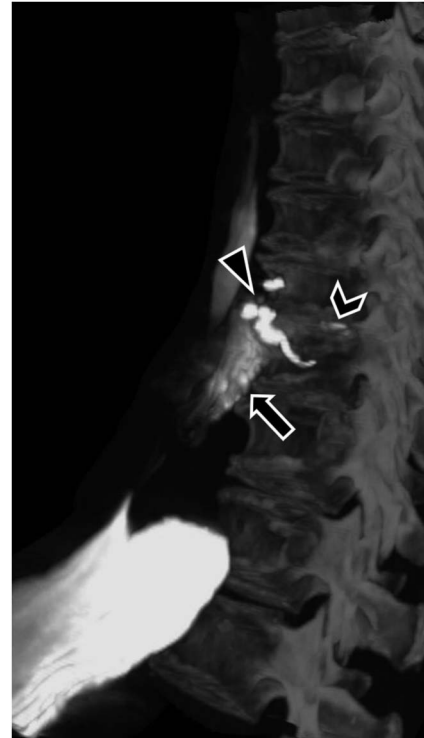


Figure 3. 3D maximum-intensity projection reconstructed from thoracic spine CT images demonstrates persistent prevertebral fluid collection (arrow) with contrast within the intervertebral disk (chevron). Embolization coils are seen in the prevertebral space superior to ulceration (arrowhead). Residual oral contrast is seen within the esophagus and stomach. CT, computed tomography.

Informed consent was obtained for this case report.

Received January 13, 2022; Accepted August 25, 2022

REFERENCES

1. Gimenez A, Franquet T, Erasmus JJ, Martinez S, Estrada P. Thoracic complications of esophageal disorders. *Radiographics*. 2002;22(Suppl 1): S247–258.
2. Sun L, Song YM, Liu LM, et al. Causes, treatment and prevention of esophageal fistulas in anterior cervical spine surgery. *Orthop Surg*. 2012; 4(4):241–6.

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