Oesophageal traction diverticulum resulting from pulmonary tuberculosis

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DESCRIPTION

A 56-year-old woman was referred with the primary complaints of bloating and abdominal burning. On prompting, she admitted to a long-standing history of reflux and constant feeling of fullness associated with a decreased appetite and 20-pound weight loss over the prior year. She denied halitosis, regurgitation of undigested food or dysphagia, but reported that she intermittently induced vomiting to relieve the bloating and fullness. A barium oesophagogram demonstrated a proximal oesophageal diverticulum at the level of aortic arch (figure 1A), which prompted a surgical referral. A gastric emptying study was normal. A flexible upper endoscopy confirmed a large proximal oesophageal diverticulum with a broad neck and without retained food (figure 1B). No other pathology was observed, and she tested negative for *Helicobacter pylori*. As all these tests did not explain her symptomatology, a CT of the chest, abdomen and pelvis was obtained. It demonstrated right upper lobe pulmonary fibrosis and a contrast-filled diverticulum of the proximal thoracic oesophagus (figure 1C). On further prompting, the patient admitted to having undergone treatment for tuberculosis over 10 years ago in Mexico, explaining her lobar fibrosis. As her symptoms were not attributable to the diverticulum, she underwent an evaluation of gastro-oesophageal reflux. A 48-hour Bravo oesophageal pH study performed on acid suppression therapy showed a DeMeester score of 2.3, suggesting that the medications were controlling her oesophageal acid exposure. A simultaneous manometry was unremarkable. She was diagnosed with functional dyspepsia, proton pump inhibitor therapy was optimised and sucralfate was added to her medical regimen. Six months later, her symptoms had resolved, and she had gained 20 pounds. No intervention was undertaken relative to the diverticulum, thus suggesting that her symptoms were secondary from reflux not warranting a diverticulectomy.

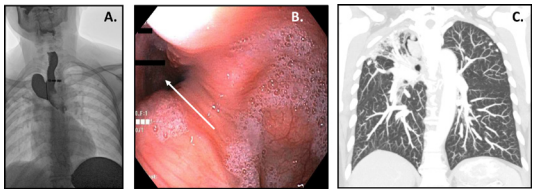

Figure 1 (A) Barium oesophagram. (B) Endoscopic view of the diverticulum. (C) Follow-up CT of the chest.

Patient's perspective

I want to share my story with others. If I can help another patient get diagnosed and managed appropriately (the way I did), I will feel rewarded.

Learning points

- Recognise the features of a traction versus pulsion diverticulum.
- Recognise the inconsistencies in a patient's symptomatology and the workup/test results. If things do not add up, make sure that you have thoroughly worked the patient up.
- Treat the patient, not the numbers or the images.

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