Oesophageal Stenosis due to Tracheo Bronchial Remnants

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ABSTRACT: Dysphagia due to an intrinsic congenital malformation causing oesophageal stenosis is rarely seen in adults. Histopathology of the obstructive lesion revealed tracheo bronchial remnants. This unusual cause of dysphagia and its surgical treatment is discussed.

KEY WORDS: oesophageal stenosis, tracheo-bronchial remnants, dysphagia

INTRODUCTION

Stenosis of the oesophagus due to an intrinsic congenital malformation is rare in adults. The association of congenital oesophageal stenosis with tracheo-bronchial remnants in the wall of the distal oesophagus has been reported earlier in infants and children.

This is a report of an adult who presented with dysphagia since childhood and was found to have stenosis of the lower third of the oesophagus due to a circumferential band of tissue containing cartilage and respiratory epithelium.

CASE REPORT

R.A., a 22 year old male, presented with difficulty in swallowing since childhood. This was progressive. Upto 12 years of age he had lived only on liquids. He started taking solids thereafter but used to feel uncomfortable. He consequently preferred liquids. He used to have epigastric pain and vomiting on and off after solid food. History of eructation

Fig. 1 Oesophagogram showing proximal dilatation of oesophagus with shouldering effect at the site of narrowing and the diverticula.
or regurgitation was absent. There were no symptoms relating to the respiratory system.

He was an ill nourished individual with no physical findings. The routine investigations including a chest x-ray were normal. Barium swallow (Fig. 1) showed evidence of narrowing at the gastro oesophageal junction with proximal dilatation of the oesophagus. The narrow segment was central in position without any irregularity. There was a shouldering effect at the site of constriction. Few small projections extending from the stricture were seen. Oesophagoscopy revealed a proximally dilated esophagus with a narrowed lumen at the lower third. There were no inflammatory changes or fibrosis.

A left posterolateral thoracotomy was performed through the seventh intercostal space and oesophagus mobilized and taped. A mass which was nodular with three nodules about 2 cm in size, was felt above the oesophagogastric junction. The lumen could not be felt through it. A wedge was taken and sent for histopathological examination, which was reported as cartilage with inflammatory cells. A local resection was decided. Cardiac end of stomach and lower end of oesophagus for about 1 cm proximal to the growth was resected, and oesophagogastric continuity restored. Diaphragm was sutured and the stomach was anchored to diaphragm. Nasogastric tube was passed into the stomach.

The post operative course was uneventful. He took liquids on the 8th post operative day, and solids 10 days after surgery. Post operative gastrograffin study was normal (Fig. 2).

Histopathological examination revealed that the tumour site showed oesophagus lined by acanthotic parakeratotic stratified squamous epithelium. On the serosal aspect was a circumscribed mass composed of cartilage and fibrosis with cystic spaces lined by pseudo stratified ciliated columnar epithelium as found in the bronchus. Few dilated mucous glands were also present. Areas of haemorrhage and lymphoid follicles were seen. In some areas the lesion was extending onto the muscle layer of the esophagus (Fig. 3).

At the cardio oesophageal junction occasional

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**Fig. 2** Photomicrograph of the nodule in the wall of oesophagus shows tracheobronchial remnants of cartilage and mucous glands with pseudo stratified ciliated columnar epithelium H & E x 70.

**Fig. 3** Post operative oesophagogram shows free flow of dye with no residual obstruction.