

## Case Report

# Aortic Pseudoaneurysm Secondary to Mediastinitis due to Esophageal Perforation

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Esophageal perforation is a condition associated with high morbidity and mortality rates; it requires early diagnosis and treatment. The most common complication of esophageal rupture is mediastinitis. There are several case reports in the literature of mediastinitis secondary to esophageal perforation and development of aortic pseudoaneurysm as a complication. We report the case of a patient with an 8-day history of esophageal perforation due to foreign body (fishbone) with mediastinitis and aortic pseudoaneurysm. The diagnosis was made using Computed Tomography (CT) with intravenous and oral water-soluble contrast material. An esophagogastroduodenoscopy did not detect the perforation.

## 1. Case Report

A 54-year-old female patient was admitted to the emergency department with an 8-day history of epigastric pain that began one day after eating fish. She consulted at another institution five days before, where she underwent esophagogastroduodenoscopy that did not reveal any foreign body or esophageal abnormalities. The symptoms got worse despite antacids and analgesic therapy so she consulted at our institution. She has a personal history of type 2 diabetes mellitus. The physical examination revealed tachycardia and intense epigastric pain on palpation.

The hepatic biochemistry and blood amylase levels were within the normal range. A complete blood count documented leukocytosis ( $18,500 \text{ cells/mm}^3$ ) with neutrophilia (85.3%) and positive C-reactive protein (161.8 mg/L).

Contrast enhanced thoracic and abdominal Computed Tomography was performed. The CT scan showed the presence of a pseudoaneurysm of the thoracic aorta, thickening of the esophageal wall, and abnormal density of the mediastinal fat with air bubbles within it that suggested mediastinitis. There was no evidence of contrast material extravasation from the esophageal lumen (Figure 1).

An aortic endoprosthesis was placed and a second CT scan was performed using oral hydrosoluble contrast material. Leakage of the contrast material to the posterior mediastinum, approximately 6 cm below the carina, was clearly seen (Figure 2).

A second esophagogastroduodenoscopy confirmed an esophageal perforation. An esophageal stent was placed. The patient was then taken to surgery (right posterolateral thoracotomy) to drain the mediastinitis, debride the necrotic tissue, and perform transposition of a pedicled intercostal muscle flap to cover the esophageal defect. The patient had a satisfactory evolution.

## 2. Discussion

Esophageal perforations can be spontaneous or secondary to trauma, iatrogenic lesions, foreign body ingestion, and tumoral processes [1, 2]. The presence of foreign bodies is a frequent condition [3]. Ingested sharp-pointed objects lodged in the esophagus are a medical emergency. These elements may pass through the esophagus without affecting the esophageal structure (80% of the cases) but 10 to 20% of ingested foreign bodies will require endoscopic removal