Primary mediastinal abscess diagnosed by EBUS-TB NA: to resect or not to resect?

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Here are two cases of a mediastinal abscess, who were diagnosed by EBUS-TBNA. A 61-year-old asian female with a history of bronchiectasis for 20 years presented with one week of progressive dysphagia and throat pain. She complained anorexia, non-productive cough, and dyspnea. On initial presentation her blood pressure was 110/70, heart rate 96, respiratory rate 20 and pulse ox was 91%. For exclusion of esophageal cancer, EGD was performed, there are no specific lesion. A chest CT scan showed bronchiectasis with mucus plugging and patchy consolidations in the both hemithorax and a 6.5 cm sized multiloculated necrotic lesion in the mediastium. He was started on Piperacillin/Tazobactam. She underwent an EBUS-TBNA for rule out a malignancy. On EBUS the mass was consist of heterogenous hypoechoic mass, irregular margin. The histopathology of the mass showed only suppurative inflammation exudates with small number or necrotic epithelial cell clusters. Sputum cultures grew Pseudomonas aeruginosa. We considered operation, but her pulmonary function is very poor (FEV1: 0.85L, FEV1/FVC 56%), and the patient refused. She was treated conservatively with antibiotics for 3 weeks, and then, discharged. The other case is a 50-year-old woman presented symptoms of cough and aggravating dyspnea. The patient subsequently had a chest CT scan that showed a 8.5 cm large mediastinal mass in middle and posterior mediastinum with adjacent upper thoracic vertebral bodies of destruction. EBUS showed heterogeneous floating inner materials. A EBUS-TBNA was performed which showed only inflammatory exudates. She was operated through thoracic incision. The resected tissue was proven to be a chronic granulomatous inflammation with caseous necrosis. The immunohistochemical staining was positive for AFB, TB-PCR and negative for PAS and GMS. Sputum cultures grew Non T.B Mycobacterium. She had complication of esophageal leakage POD 42. So we treated her with esophageal stent. These cases are rare in that primary abscess in the mediastinum, are more uncommon in immunocompetent hosts. Patients presented with non-specific symptoms and a mass that was initially concerning for malignancy. Treatment of mediastinal abscess is controversial, yet.

Stevens-Johnson syndrome and hypothermia associated with antituberculosis medication

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Introduction: We herein present a case of 76-year-old man who showed severe adverse effects of anti-TB medication, including Stevens-Johnson syndrome (SJS), hypothermia, and lactic acidosis. Case Report: A 76-year-old man with congestive heart failure, atrial fibrillation, pericardial effusion, and pleural effusion was diagnosed of pulmonary TB with mediastinal lymphadenopathy and constrictive pericarditis (Fig. A, B). After 8 weeks Anti-TB treatment, he showed generalized cutaneous exanthema consisting of crusts and erythematous plaques on the patient’s trunk and diagnosed with SJS with xerosis cutis (Fig. C). And he also demonstrated hypothermia below 35°C and sustained lactic acidosis. After careful fluid therapy and inotropic agents with external warming, skin lesion and general condition gradually improved (Fig. D). Discussions: SJS and toxic epidermal necrolysis are life-threatening cutaneous drug reactions in which cell death causes the epidermis to separate from the dermis. SJS and toxic epidermal necrolysis involve 30% of the body surface, respectively. SJS, hypothermia, lactic acidosis, and aggravated constrictive pericarditis are possible adverse effects of anti-TB therapy, but in this case, these various severe side effects occurred simultaneously. Because treating TB in patients with underlying diseases can cause multiple problems or aggravate underlying diseases, attention is required to understand the early signs of adverse effects and address them rapidly and appropriately.