**CASE STUDY**

**Oesophagocutaneous fistula - a rare complication of thyroidectomy for benign goitre**

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**Keywords:** Thyroidectomy; oesophagocutaneous fistula; gastric heterotopia.

**Case presentation**

A 26 year old female resident of Western Maharashtra (India) presented with a salivary fistula on the anterior aspect of the neck. She had undergone a left hemithyroidectomy for left lobe goitre at a private hospital 4 weeks back. She had a history of goitre for six months. There was no history of hoarseness of voice, dysphagia or dyspnoea. Operative notes did not mention about intra operative oesophageal injury. On the fifth postoperative day the entire wound dehisced and the patient developed a large salivary fistula. In the same institute the salivary fistula was initially managed conservatively. Nasogastric intubation was tried but failed even under fluoroscopic guidance. A feeding jejunostomy was done. The histopathological report of the goitre was benign.

![Figure 1: Showing oesophagocutaneous fistula with scar of thyroid surgery](image)

**Figure 2: Pre and Post operative Barium swallows**

She was referred to our institute for further management. There was no hoarseness or change of voice. On local examination there was a scar of Kocher’s incision with a centrally located salivary fistula (figure 1). A feeding jejunostomy was present. Indirect laryngoscopy did not reveal any abnormality. Barium swallow was suggestive of blind ending proximal oesophagus with an oesophagocutaneous fistula (figure 2). Distal oesophagus could not be visualized on endoscopy. Broad spectrum antibiotics were started.

Local exploration and end to end anastomosis was planned. Intraoperatively there was intense fibrosis all around. A nasogastric intubation was tried intraoperatively and the Ryle's tube was seen abutting the upper blind pouch. A stricturous segment 2-3 cm long was evident between the proximal and distal oesophageal pouches. Upper pouch was opened and nasogastric tube was retrieved. Distal oesophagus was mobilized. The strictured segment was excised. A single layer primary anastomosis was done (with polyglycolic acid).
The outcome of conservative management has a better prognosis in injuries recognised early and in cervical oesophageal injury [3,4]. In the index case the injury was not recognised early which probably led to the formation of stricture at the site of injury causing oesophageal luminal obstruction and fistula.

Case reports of patients with gastric heterotopia in the oesophagus, ranging from spontaneous tracheoesophageal fistula to esophagitis like symptoms due to acid secretion from the gastric heterotopias, have already been reported in literature. But a review of the literature did not reveal its association of with oesophagocutaneous fistula following thyroid surgeries [3,5]. However in the index case, the finding of gastric heterotopia seems to be coincidental. The finding of a long stricturous segment seems more like a sequel of the operative injury. The previous reported cases of oesophagocutaneous fistula following thyroid surgery have not mentioned presence or absence of gastric heterotopias [3,5].

**References**

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**Learning Points:**

- Surgery involving anterior triangle of neck presenting with post operative salivary fistula should be investigated early with investigations like fistulogram, endoscopy etc, for definitive diagnosis and early initiation of treatment.

- Treatment choices range from conservative to surgical methods such as esophageal repair by primary suturing and drainage, repair with flaps for esophageal fistula and esophageal resection.

- A conservative management has better prognosis in injuries recognised early.