A previously healthy 34-year-old man presented with severe chest pain, with cough and dyspnea lasting for 2 days. The chest pain had begun after a dinner and the consumption of alcohol, but he denied the ingestion of any foreign body. On physical examination, no palpable mass was observed on the neck, and his lungs were clear on auscultation. His laboratory results at presentation showed significant increases of white blood cells (23.02×10⁹/L), with 90% neutrophils, and C-reactive protein level (180 mg/L). Other tests including serology for cytomegalovirus (CMV) and tuberculosis were within normal limits. A contrast-enhanced computed tomography (CT) scan revealed wall thickening and a low density accumulation in the upper and middle esophagus (▶Fig. 1). Endoscopic examination revealed a longitudinal bulge at 20–30 cm distal to the incisors (▶Fig. 2). The patient was prescribed ciprofloxacin 400 mg intravenously; however, he complained of a fever and chills 2 days later. A three-dimensional reconstruction technique was used to facilitate diagnosis and characterize the esophageal lesion (▶Fig. 3). Notably, repeat endoscopy showed pus flowing from a fistula at the upper part of the esophageal bulge, consistent with a diagnosis of esophageal abscess (▶Fig. 4a). With the patient under general anesthesia, an endoscopic incision was performed from the fistula to the end of the bulge using an insulated-tip knife (▶Fig. 4b; ▶Video 1). This endoscopic mucosal incision released a large amount of pus and the esophageal wall was intact. Postoperatively, both the patient’s condition and laboratory tests immediately improved. The intramural esophageal abscess was no longer visible on endoscopy or CT examination 3 days postoperatively. On further endoscopic examination, 1 month later, the esophageal longitudinal ulcer from the incision was found to have healed (▶Fig. 4c).
The treatment of choice for an intramural esophageal abscess.

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Competing interests

The authors declare that they have no conflict of interest.

References


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