



LETTERS TO THE EDITOR

Response to “Cervicothoracic abscess secondary to transesophageal ultrasound-guided fine needle aspiration”[☆]



Respuesta a «Absceso cervicotorácico secundario a punción con aguja fina guiada por ecografía endoscópica transesofágica»

Dear Editor,

We read with interest the scientific letter published recently in your journal by Tejero-Pintor et al.,¹ in which a case of cervical-thoracic abscess is reported in apparent relation to a transesophageal endoscopic ultrasound-guided fine-needle aspiration biopsy (FNAB). However, after careful assessment of the letter, we found several details which, at the very least, cast doubt on this aetiological relationship. On the one hand, a week after the FNAB, as they did not have a conclusive result from the biopsy, the patient underwent a video-thoracoscopy, and the symptoms of the neck abscess did not start until two weeks after that. On the other, the sequence of events and the access route for the thoracoscopy mean that it cannot be ruled out as the actual cause of the infectious complication. Lastly, it would also be expected that in the surgical exploration performed seven days after the endoscopy, signs suggestive of this supposed endoscopy complication would have been detectable by then in the cervical-thoracic area examined, something which also does not concur in this case. We agree with the authors that the bacterium isolated (*Streptococcus viridans*) is one of the usual commensals of the oropharyngeal flora, and that it being isolated in the culture could therefore be due to spread from the endoscopy. However, it is also known that in a considerable proportion of infections of this aetiology the origin of the bacterium is the skin (12%), and up

to 15% are of unknown origin,² which again makes us reconsider the hypothesis of the pharyngeal-gastrointestinal focus as the only potential source.

Examining all these factors together, we believe that the causal relationship on which the title of the letter is based is not adequately supported by the chronological factors described, the subsequent performing of other invasive investigations in the same area and the possibility of the source of the bacteria being other than the gastrointestinal tract, never mind the additional factor that this was an immunosuppressed patient.

The current clinical guidelines for gastrointestinal endoscopic ultrasound³ only recommend antibiotic prophylaxis in the case of puncture of mediastinal lesions with cystic component. If in the future these recommendations are to be extended to all types of mediastinal lesions or to patients under special circumstances (immunocompromised/immunosuppression), this will be clarified by scientific evidence accumulated either from cases or case series which have correctly documented aetiological attribution or from quality comparative studies.

References

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