tuberculosis or mediastinal, paratracheal or thoracic outlet mass.

Oesophageal tuberculosis may be caused by swallowing infected sputum, direct spread from lung, mediastinal nodes or spine, or by retrograde lymphatic spread[1]. The rarity of oesophageal tuberculosis can be partly explained by protective mechanisms such as the stratified squamous epithelial lining, the tubular structure and short transit time through the oesophagus, which prevent prolonged contact of swallowed infectious material with the mucosa. With regard to spread of tuberculosis from mediastinal lymph nodes to the oesophagus, it has been postulated that caseous nodes causing oesophageal compression may erode into the lumen causing oesophageal ulceration. By the same mechanism, tuberculous mediastinal nodes can erode into the bronchus and tracheo-oesophageal fistula is also a known complication of tuberculous mediastinal lymphadenopathy[3].

The diagnosis of oesophageal tuberculosis depends on demonstration of caseous granuloma or acid fast bacilli in the lesion. Some authors have resorted to culturing the biopsy to establish the diagnosis[2]. In cases where there is strong clinical suspicion but no bacteriological or histological confirmation, a trial of anti-tuberculosis therapy may be useful. The treatment of oesophageal tuberculosis is primarily medical and a full course of combination anti-tuberculosis drug therapy should be given.

Although there was no bacteriological confirmation of tuberculosis in our case, the diagnosis was supported by the history of contact with tuberculosis, positive tuberculin test, histological evidence of caseating granuloma on oesophageal biopsy and rapid response to anti-tuberculosis treatment. Her chest X-ray and barium swallow did not indicate the presence of pulmonary tuberculosis or mediastinal lymphadenopathy but a small focus may have been missed. A C.T. scan of the chest would have been helpful but was not done in this patient. This case illustrates well the multi-disciplinary approach often necessary in the management of extrapulmonary tuberculosis since this patient benefited from discussion and collaboration between the Surgeon, Radiologist, Pathologist and Physician.

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