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Dysphagia and stenosis secondary to intramural esophageal pseudodiverticulosis

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Conflict of interest
The authors declare that they have no conflicts of interest.

Dear Editor,

We present the case of a 58-year-old man with a history of smoking, alcoholism, liver cirrhosis due to hepatitis C virus, and HIV infection with good immune control. In 2018, he reported dysphagia to solids and retrosternal pain so a computed tomography (CT) was performed, which showed concentric thickening of the esophageal walls. After that an upper gastrointestinal endoscopy was done showing whitish exudates with a diagnosis of candidal esophagitis. After the treatment with antifungals and proton pump inhibitors (PPIs), the patient showed clinical improvement. In 2021, the dysphagia began again and the patient presented an episode of food impaction resolved endoscopically. The gastroscopy showed a short distal concentric stenosis that did not allow the passage of the endoscope, as well as multiple diffuse millimetric esophageal pseudodiverticula and two larger proximal ones, with scars and food remains adhered by stasis. Biopsies only showed chronic nonspecific esophagitis. In order to solve the stenosis, two sessions of endoscopic
pneumatic dilatation were done, allowing the passage and leaving the patient asymptomatic. Treatment with PPI is continued.

Discussion
Esophageal intramural pseudodiverticulosis (EIP) is a benign condition that presents as dysphagia in more than 80% of patients. The condition is rare and pathogenesis is caused by either obstruction of excretory ducts or motor disorders of the esophageal wall that lead to ductal dilation. This can frequently produce motor disorders and stenosis secondary to parietal fibrosis (1, 5). It is slightly more common in men around 50-60 years of age (1, 3). There are many published cases that develop in patients with HIV, as explained in Plaza R et al (1) or in our case, although the causal association between the two is questionable (1, 2). On the other hand, it has been associated with alcoholism, smoking, diabetes mellitus, gastroesophageal reflux and esophageal candidiasis (up to 25%) (2-5). The symptoms vary from asymptomatic patients to dysphagia (a more common symptom even without stenosis, in 80%), impaction or chest pain (1-4). The diagnosis can be difficult because only 20% are visualized endoscopically (in addition, biopsies only show non-specific inflammation). They are better identified with an esophagram or CT (characteristic of concentric thickening of the esophageal walls). Treatment is based on controlling risk factors (alcoholic withdrawal, PPI, antifungal treatment, etc.) and stricture dilatation. The clinical course and prognosis are usually favorable in the majority of cases (1-5).

References


Figure 1. A. Endoscopic image showing small esophageal pseudodiverticula with scar areas and food stasis. B. Image of the same patient showing larger pseudodiverticula. C. Endoscopic image showing controlled mucosal tear after pneumatic balloon dilation of esophageal stricture.