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Russell body esophagitis and Barrett's esophagus

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Dear Editor,

We present the case of an 85-year-old woman with a history of hypertension, type 2 diabetes, dyslipidemia and chronic renal failure who came to the emergency department for general malaise and asthenia. Laboratory tests showed anemia, so abdominal CT and gastroscopy were performed.

The gastroscopy showed two raised erythematous areas of metaplastic appearance in the distal esophagus, which were biopsied, and a prominent prepyloric fold in the gastric cavity, which was also biopsied.

Histologic study of the distal esophagus reveals a gastroesophageal junction mucosa with chronic lymphoplasmacytic inflammation with Russell bodies (Fig 1) and granulation tissue. Although initially there was no evidence of intestinal metaplasia, deeper levels of the submitted specimen revealed Barrett's esophagus without dysplasia. The gastric biopsy showed mild chronic inactive gastritis without the presence of H. pylori or enteric metaplasia.

Esophagitis with Russell bodies is a form of chronic inflammation of the esophageal mucosa containing plasma cells with accumulation of prominent intracytoplasmic Russell bodies[1]. Russell bodies are thought to result from the cellular response to plasma cell overstimulation in chronic inflammation, resulting in condensed

immunoglobulin in dilated endoplasmic reticulum cisternae[1,2]. These plasma cells are called Mott cells[1,2].

The pathogenesis is uncertain; an association with H.Pylori, inflammatory states and chronic lesions such as intestinal metaplasia and gastric mucosal atrophy among others have been suggested[3].

Clinically they usually present with nonspecific gastrointestinal tract symptoms, with Russell bodies being incidental findings in biopsies. The gastric location is the most common location, being extremely rare in the esophagus. In the esophagus, in the review[4] that documents the most cases, in most patients the presence of Russell bodies coexists with Barrett's esophagus.

For a correct differential diagnosis[2] it is necessary to rule out hematologic neoplasms as well as signet ring cell carcinoma. To this end, in complex cases, an immunohistochemical panel[3] with epithelial markers (cytokeratins), plasma cell markers (CD 138) and light chains (kappa and lambda) can be used.

Although treatment of this entity is not well defined, it is proposed to eradicate H. Pylori in cases where it is present, and to prioritize the management of Barrett's esophagus[3] .

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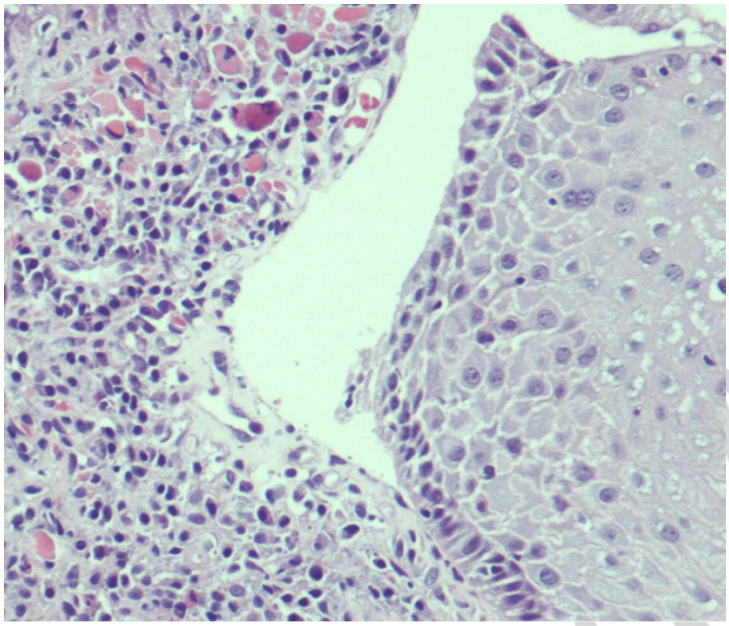

Fig 1: Esophageal mucosa in whose lamina propia a lymphoplasmacytic infiltrate with the presence of Russell cells is observed.