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PICTURES IN DIGESTIVE PATHOLOGY

Spontaneous intramural esophageal dissection: an unusual onset of eosinophilic esophagitis

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BACKGROUND

Eosinophilic esophagitis (EoE) is becoming a more frequent cause of dysphagia in young men, typically associated with atopy and characteristic endoscopic features. It is known for being a cause of esophageal perforation but only few cases of intramural esophageal dissection have been described (1-4).

CASE REPORT

A 35-year-old man, with a history of rhinitis, eczema and diagnosed with a dubious achalasia in his youth, was admitted to the emergency room due to chest pain, nausea and sialorrhea over the past three weeks. The vital signs were stable and laboratory workup showed no alterations. Upper gastrointestinal endoscopy revealed a little hole and a narrowing of the distal esophagus, probably by extrinsic compression. Therefore, a CT-scan with oral contrast was performed, which exposed a discontinuity of the lumen of the middle third of the esophagus and a dissection of submucosal space 16 cm in length, extending from D3 to D10 (cardia), which compressed the lumen of the distal esophagus (Fig. 1 A-C). There were no signs of fistulization to mediastinum. Considering his medical record of rhinitis, eczema and dysphagia, and the current intramural esophageal dissection, the diagnosis of EoE was raised. The patient recovered after antibiotic, omeprazole, fasting and parenteral nutrition and was gradually started on feeds. A CT-scan three months later indicated a decrease in size of the previous findings. Treatment with proton-pump inhibitors was continued and after four months an upper gastrointestinal endoscopy was repeated. This showed transient whitish exudates, longitudinal furrows, edema and esophageal lacerations. The biopsies illustrated significant eosinophilic inflammation isolated in the esophagus, eosinophilic microabscesses and basal cell hyperplasia (Fig. 2).

DISCUSSION

As shown in the current case, the diagnosis of EoE must be considered when finding an intramural esophageal dissection in a patient with dysphagia in an appropriate clin-

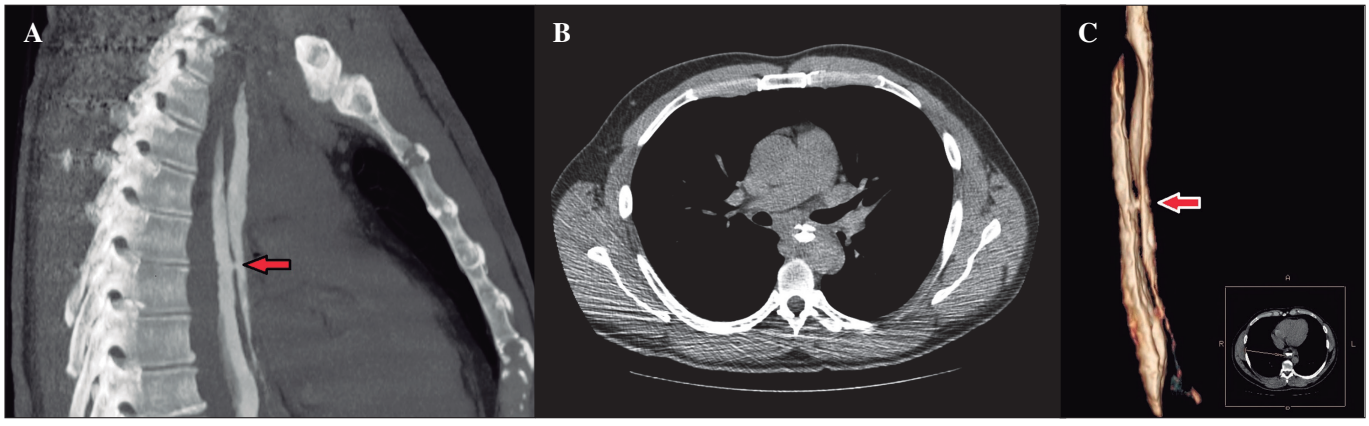

Fig. 1. A. Unenhanced CT with oral contrast at onset of symptoms. Esophageal wall dissection extending from D3 to D10 is evidenced. The false lumen, on the left, compresses the distal true esophagus. The red arrow marks the communication between both lumens. There are no signs of fistulation to mediastinum. B. Axial unenhanced CT demonstrates opacification of the two lumen as a consequence of esophageal dissection. True esophageal lumen is anterior and false lumen due to esophageal dissection is posterior. C. Volume rendering with suppression of the surrounding tissue. The esophagogram shows a dissection of submucosal space 16 cm long. The true lumen is on the right and the false lumen on the left. The red arrow marks the communication between both.

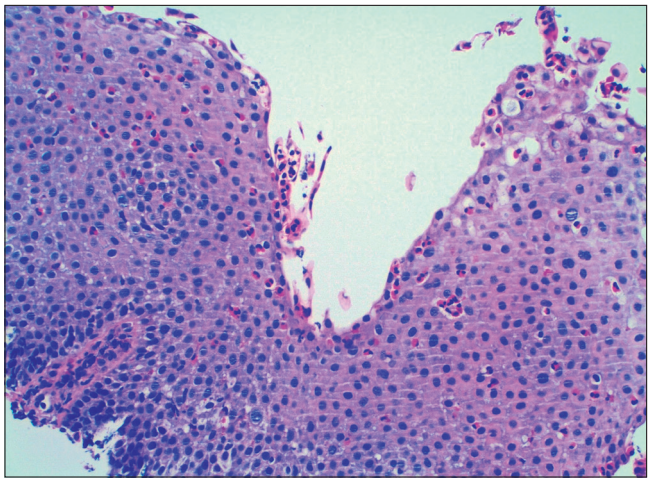

Fig. 2. Esophageal biopsies after four months illustrated greater than 15 eosinophils per high power field (20x) and basal cell hyperplasia confirming eosinophilic esophagitis.

ical background and then, if it is possible, conservative treatment should be taken into account (5).

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