Massive Submucosal Esophageal Tear From Meat Impaction in Candida Esophagitis

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CASE

Introduction:

•Candida species are commensal organisms of different mucous membranes in healthy individuals with the esophagus being a common site of colonization[1].

•Candida esophagitis involves the superficial mucosa and transmural invasive candida infection is rare even in immunocompromised patients[2].

•Candida esophagitis rarely involves life-threatening complications (i.e. deep esophageal tear, necrosis, perforation)[3].

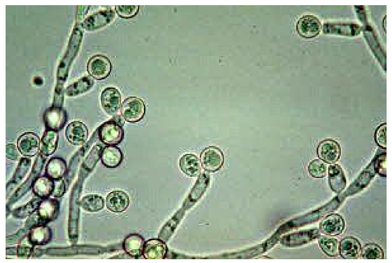


Figure 1. Candida Albicans[4]

Case Description: The patient is a 49 year-old male with history of hypertension that presents with a food impaction in his esophagus after eating steak.

•He tried to relieve the impaction with self-induced vomiting without relief followed by multiple episodes of hematemesis associated with dysphagia, odynophagia, and severe chest pain.

•He reports being in usual state of health prior to that incident.

•No NSAIDs, alcohol abuse, or smoking history. No chronic steroids, PPI, or anticoagulant use.

•Physical examination: Sclera nonicteric, no oral thrush, no palpable crepitus over chest wall or neck. Abdominal exam unremarkable.

CT chest showed no radiopaque foreign body or pneumomediastinum and an emergent EGD was performed (see figures 4, 5, 6, 7).

Patient was admitted under CT surgery and was kept NPO, on IV fluids, IV PPI, IV antibiotics and antifungal.

Patient was subsequently diagnosed with HIV.

IMAGES



Figure 2. CT scan of neck soft tissue. No signs of any radiopaque foreign body or pneumomediastinum.

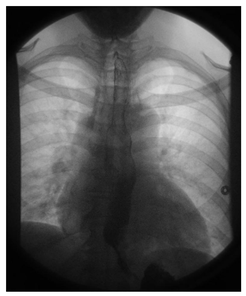


Figure 3. Barium esophagram. No extravasation of contrast. No evidence of esophageal dysmotility. No mass, stricture or other esophageal abnormality is seen.

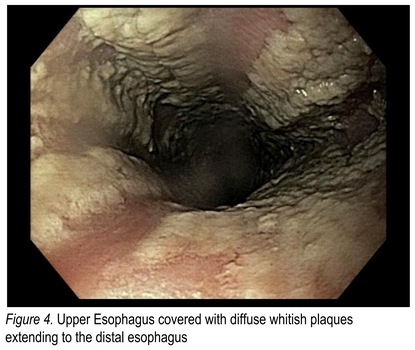


Figure 4. Upper Esophagus covered with diffuse whitish plaques extending to the distal esophagus

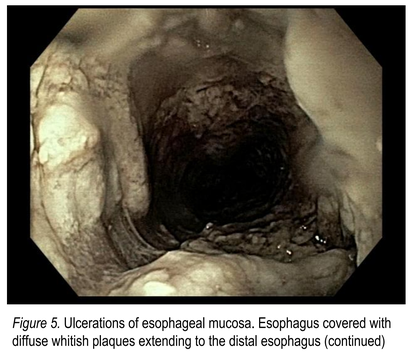


Figure 5. Ulcerations of esophageal mucosa. Esophagus covered with diffuse whitish plaques extending to the distal esophagus (continued)



Figure 6. Large deep submucosal tear extending 27 to 37 cm from the incisors.

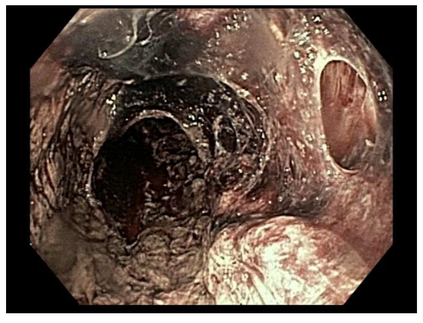


Figure 7. Large deep submucosal tear (continued)

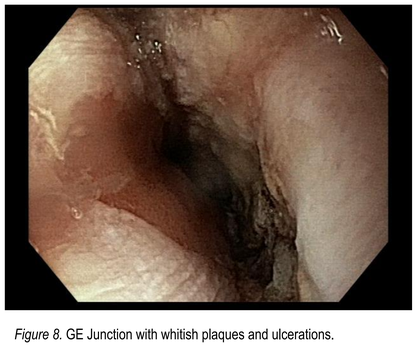


Figure 8. GE Junction with whitish plaques and ulcerations.

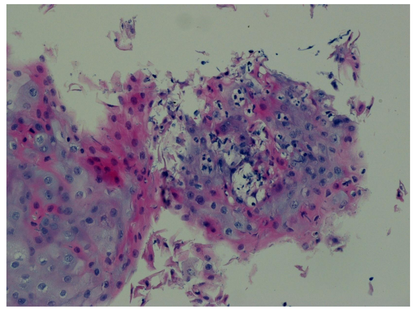


Figure 9. Esophageal biopsy from esophagogastroduodenoscopy (EGD). Abundant Candida and bacteria present.

TABLES

Bloodwork	Result
WBC [3.8-10.5 k/uL]	7.1
Hgb [13-17 g/dL]	16.7
Plt [150-400 K/uL]	308
INR [0.88-1.16]	1.08
AST [15-37 U/L]	54
ALT [12-42 U/L]	50
Albumin [3.4-5 g/dL]	3.6

Table 1. Hematology and coagulation studies were unremarkable. Mild transaminitis was noted.

Bloodwork	Result
HIV-1 RNA Quantitative, Viral Load	12214
HIV-1 Ab	Reactive
HIV-2 Ab	Nonreactive
ABS CD4 [489-1457 /uL]	169
ABS CD8 [136-757 /uL]	1412
CD4 % [36-65%]	9
CD8 % [11-36%]	75

Table 2. HIV result and CD cell count and percentage from flow cytometry.

DISCUSSION

- Candida esophagitis is known to occur in immunocompromised hosts but severe complications (i.e perforation, fistula) with esophageal candidiasis are rare and have been mainly reported in diabetic patients with renal transplantations and patients with hematologic malignancy[5].
- Unlike eosinophilic esophagitis, food impaction is not often seen in candida esophagitis[6].
- The unique highlights of this case are the absence of any prior classic symptoms of infectious esophagitis (i.e. dysphagia, odynophagia, and chest pain) or constitutional symptoms and the extent of esophageal mucosal injury sustained from the food impaction in the setting of esophageal candidiasis.

References

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