Esophageal intramural pseudodiverticulosis: A rare cause of dysphagia

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INTRODUCTION

Esophageal intramural pseudodiverticulosis is a rare cause of dysphagia. We report the case of a young patient with a long history of dysphagia who was diagnosed after the performance of an endoscopy and a barium esophagogram.

CASE REPORT

A 45-year-old man with past medical history of HIV infection on tenofovir/emtricitabine and efavirenz treatment for 7 years, with undetectable viral load and CD4 lymphocytes > 500/ml. He was smoker of 10 cigarettes per day and he was not a drinker.

He presented with a 10-year history of mild non-progressive dysphagia for solid foods.

He had had several episodes of food impaction, not requiring endoscopic extraction. He had no symptoms of odinophagia, weight loss, nausea or heartburn.

An upper gastrointestinal endoscopy was performed, and multiple tiny openings of pseudodiverticula in proximal esophagus were seen (Fig. 1). Biopsies from proximal and medium esophagus revealed there was no eosinophilic mucosal involvement.

Fig. 1. Upper gastrointestinal endoscopy: Numerous 1-2 mm tiny diverticular orifices on the mucosal surface of proximal esophagus, with no evidence of complication.
As the endoscopic findings did not clear out the patient’s symptoms, a pHmetry and esophageal manometry and a barium esophagogram were performed to complete the study.

Esophageal pHmetry and manometry revealed pathological acid reflux, besides a mild, unspecific motility disorder of the esophageal body. The cricopharyngeus was hypotense showing a normal deglutition, and the lower esophageal sphincter was normotense with incomplete and uncoordinated relaxations.

Barium esophagogram demonstrated an appearance which is pathognomonic for esophageal intramural pseudodiverticulosis (Fig. 2) and led to the definitive diagnosis of the patient and the etiology of the dysphagia.

DISCUSSION

Esophageal intramural pseudodiverticulosis (EIP) is a rare cause of dysphagia whose prevalence is not well-known. This entity was first described by Mendl in 1960. In two large radiological reports it represented 0.1 % of all patients who underwent any radiological evaluation due to different pathologies. It affects both genders, although it has a slight male predominance and the average age at presentation is between the sixties and seventies (1,2).

The pathogenesis is related to hypertrophical submucosal glands, with cystic dilation of the excretory ducts and hence, it is not true diverticulosis. It is associated with parietal mioneurovascular functional changes and sometimes with esophageal strictures in middle and proximal esophagus, due to submucosal fibrosis (2).

The most common symptom observed is intermittent dysphagia to solid foods, though sometimes it can be asymptomatic. Esophageal candidiasis is frequent in more than 25 % of cases, and it is related to stasis (3). There appear to be no relationship between this entity and an underlying immunological disease, though cases reported in HIV patients are extremely rare (4).

The treatment should be directed towards treating esophagitis if there is pathological reflux disease. When there is a stricture, endoscopic dilatation should be performed, but repeated bougienage may be necessary to achieve patient’s clinical relief (2,3).

REFERENCES