OESOPHAGITIS DISSECANS SUPERFICIALIS – AN UNUSUAL ENDOSCOPIC FINDING

Editor,

Oesophagitis dissecans superficialis (ODS) is a desquamative oesophageal disorder, characterised by sheets of sloughed squamous tissue with normal underlying mucosa. It is extremely rare and benign. We describe a case of ODS and discuss the condition.

An 83-year-old female was admitted to hospital with a 4 day history of vomiting and central cramping abdominal pain. On abdominal examination, there was epigastric tenderness with intermittent guarding. Abdominal radiograph showed faecal loading.

The impression was gastritis and constipation. A Computed Tomography scan of the abdomen and pelvis was carried out, due to suspicion of ischaemic bowel and showed no acute intra-abdominal pathology. The scan report noted that the stomach fundus appeared slightly thick-walled and advised an oesophago-gastro-duodenoscopy (OGD).

The OGD showed ODS in the oesophagus (Figure 1), and a small hiatus hernia. The stomach and duodenum appeared normal. Biopsies were taken. The oesophagus showed patchy acute mild inflammation with epithelial hyperplasia and parakeratosis. Periodic acid-Schiff stain showed scattered Candida organisms. The gastric body mucosa showed some cystic dilatation of glands suggestive of a fundic-type polyp, with no evidence of dysplasia.

The patient was prescribed laxatives and anti-emetics. Over several days, her nausea and constipation resolved.

ODS is a desquamative oesophageal disorder, involving sloughing of the superficial mucosa. It is extremely rare, with one study reporting an incidence of 0.03%. It usually affects adults after age 50 and is slightly more common in women than men.

ODS can be idiopathic or secondary to oesophageal mucosal injury which may be due to bisphosphonates and non-steroidal anti-inflammatory medications, certain foods, or repeated vomiting. It is also associated with systemic diseases, such as pemphigus vulgaris and coeliac disease. In this case, the patient was not taking any associated medications and did not have any associated systemic diseases.

It is usually asymptomatic and discovered incidentally, which was likely to be the case in our patient. It can occasionally be associated with dysphagia, nausea, bleeding, vomiting, heartburn, epigastric pain, and odynophagia. The abdominal pain in our patient’s case was felt more likely to be due to constipation rather than her ODS, as the pain improved following successful laxative use.

It has been suggested that meeting 3 of the following endoscopic criteria is consistent with ODS: “(1) strip(s) of sloughed oesophageal mucosa >2cm in length; (2) normal underlying oesophageal mucosa; and (3) lack of ulcerations or friability of immediately adjacent oesophageal mucosa.”

Biopsies are not always necessary, but should be performed if the patient is symptomatic, a coexisting diagnosis may be present, or the endoscopic features are not classical.

The most common histological findings are parakeratosis and intraepithelial splitting, although these are non-specific. Biopsies may show inflammation, and there may be associated fungal elements. In our patient’s case, Candida was noted.

Whilst there are no clear guidelines for the management of ODS, it has been reported that stopping any potential causative medications and use of acid-suppressing medications results in resolution. ODS is benign and does not cause permanent damage.

It is important to raise awareness of ODS. One study reported that only 41.5% of cases were correctly identified at endoscopy. Gastroenterologists’ unfamiliarity with this condition may cause it to be mistaken for other diseases.

REFERENCES

1. Evenson ML, Hinds MW, Bernstein RS, Bergdoll MS. Estimation of human dose of staphylococcal enterotoxin A from a large outbreak of staphylococcal food poisoning involving chocolate milk. Int J Food Microbiol. 1988;7(4):311-6.
2. Hennekinne JA, DeBuyser ML, Dragacci S. Staphylococcus aureus and its food poisoning toxins: characterization and outbreak investigation. FEMS Microbiol Rev. 2012;36(4):815-36.
3. Moore JE, Shaw A, Millar BC, Downey DG, Murphy PG, Elborn JS. Microbial ecology of the cystic fibrosis lung: does microflora type influence microbial loading? Br J Biomed Sci. 2005;62(4):175-8.
4. Collery MM, Smyth DS, Twohig JM, Shore AC, Coleman DC, Smyth CJ. Staphylococcus aureus from an Irish university student population based on toxin gene PCR, agr locus types and multiple locus, variable number tandem repeat analysis. J Med Microbiol. 2008;57(3):348-58.
Collateral Thinking

Editor,

We present a rare and challenging case of a patient presenting with ectopic variceal haemorrhage. A 57 year old man with a background of alcohol related liver cirrhosis (Child Pugh A6, MELD 10) presented with 3 episodes of frank bleeding from his umbilicus over a 4 day period. Variceal surveillance with OGD in March 2017 was negative and other significant medical history included alcohol dependence, morbid obesity, type 2 diabetes mellitus and COPD.

Abdominal examination showed caput medusae that had been oversewn in the emergency department; there was no detectable ascites or asterixis. Doppler ultrasound of liver revealed patent hepatic vasculature. Subsequent CT confirmed cirrhotic appearances of the liver with features of portal hypertension, recanalisation of the umbilical vein and varices measuring up to 2cm in diameter within an umbilical hernia (Figure 1 and 2).

Following a further episode of bleeding from the umbilicus 48 hours post-admission, his haemoglobin fell from 113 g/L (130 – 180 g/L) to 62 g/L. He was managed as per gastrointestinal variceal haemorrhage with transfusion of packed red cells, terlipressin and prophylactic antibiotics.

Fig 1. CT showing sizeable umbilical varices
(white arrowhead)

Fig 2. Catheterisation of umbilical varices

Fig 3. TIPSS insertion