LETTER TO THE EDITOR

Severe esophageal Crohn’s disease: Healing of lesions after 1 week therapy with infliximab

To the Editor:

A 38-year-old woman was admitted for axial articular pain associated to a bloody diarrhoea, abdominal pain, weight loss and fever. She also complains of odinophagia, progressive dysphagia, nausea and chest pain; also, she had an history of perianal fistulae.

Laboratory findings revealed a moderate anemia (Hb 9.7 g/dl) with an increased ESR and CRP.

A colonoscopy with histologic examination indicated a severe Crohn’s disease (CD) of the terminal ileum and right colon. A CT scan excluded active fistulae or perianal abscesses while MRI showed the presence of a sacro-ileitis complicating CD.

An upper endoscopy revealed deep ulcers, aphthae, and punched-out ulcers at the medium and lower third of the esophagus (Fig. 1A). The histology demonstrated a lymphoplasmacytic infiltration of epithelium which extended into the lamina propria destroying the muscular layer; granulomas were not detected. CMV-PCR and immunohistochemical staining for HSV proved to be negative.

Finally the diagnosis of non-stricturing/non-penetrating esophageal-ileal-colonic CD was made. The patient was treated with IFX (5 mg/kg) with an early and good clinical response (CDAI Δ: 120). After 1 week from the administration of IFX a second upper endoscopy showed the mucosal healing of the oesophageal lesions (Fig. 1B). The patient was set to complete the induction therapy with IFX followed by a maintenance therapy with an administration every 8 weeks. After three months from the beginning of treatment she still remained in clinical and endoscopic remission (Fig. 1C).

CD of the oesophagus is uncommon and rarely the involvement of the oesophagus is the presenting feature of the disease. Isolated involvement of the oesophagus is an extremely rare presentation of CD and only 10 cases have been reported.1 Decker and colleagues reported on 20 cases of oesophageal CD between 1976 and 1998 at Mayo Clinic Rochester and they remarked that extraoesophageal CD preceded or was found at same time as the diagnosis of esophageal CD in all patients as in our case.2 Usually dysphagia, odynophagia, chest pain after swallowing are the most common symptoms, being associated with a esophageal aphthosis, erosions, deep ulcers, polyoid inflammatory lesions, mucosal bridges, strictures and perforation with esophagobronchial and oesophago gastric fistulae.2

CD of the oesophagus seems to be associated with a worse prognosis. Although controlled trials are lacking, oesophageal CD may be best treated with PPIs, if necessary together with systemic corticosteroids and immunosuppressors.2 Infliximab (IFX) and other biologic therapies are an alternative for severe or refractory CD and could be an effective option in treating severe esophageal CD.3,4

Severe esophageal CD involvement seems to be a direct indication to anti-TNFα therapy, also independently to the disease activity of the other disease locations. The remarkable short-term outcome of infliximab in our patient confirms its efficacy in treatment of severe CD.

References


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Figure 1  Upper gastrointestinal endoscopy showing deep ulcers, aphthae and punched-out ulcers at the medium and lower third of the esophagus (A). Mucosal healing of the esophageal lesions after 1 week from the administration of IFX (B). Endoscopic remission after 3 months from the beginning of treatment (C).