Case report

The Pea, the yeast and the prostate

Y. PASHA1, D. BLUNT2 and P.T.F. KENNEDY3

From the 1Department of Gastroenterology, Charing Cross Hospital, Fulham Palace Road, London, W6 8RF, 2Consultant Radiologist and 3Consultant Gastroenterologist, Charing Cross Hospital, Fulham Palace Road W6 8RF, UK

Address correspondence to Y. Pasha, Department of Gastroenterology, Hillingdon Hospital, Pield Heath Road, UK. email: yasminpasha@doctors.org.uk

Case reports

A 59-year-old male was referred with an intermittent history of dysphagia for solids. Initial gastroscopy showed oesophageal candidiasis only, subsequently confirmed on histology.

Five weeks later, he presented with a 24-h history of complete dysphagia. He was assessed in the Emergency Department by the Ear, Nose and Throat service and fibre optic nasendoscopy, was performed, which was non-diagnostic. An emergent barium swallow was undertaken. (Figure 1) What does this show?

Repeat gastroscopy demonstrated a tight oesophageal stricture in the proximal oesophagus with complete luminal obstruction caused by a green pea (Figure 2). The stricture precluded passage of the scope into the distal oesophagus. Although the stricture had benign macroscopic appearances, multiple biopsies were taken. In view of the radiological and endoscopic findings, a therapeutic course of oral fluconazole was prescribed.

On specific questioning, a history of bony pain localized to the thoracic spine was elicited. Suspicious plain radiography necessitated a bone scan, which revealed multiple bony metastases. Computed tomography of the chest, abdomen and pelvis reported a long segment of circumferential thickening of the upper and mid-oesophagus but no obvious primary lesion identified.

Stricture histology confirmed a benign process with evidence of reflux oesophagitis only. No fungal hyphae were identified microscopically. A full complement of tumour markers revealed an elevated prostatic specific antigen (PSA), which had been within the normal range 3 months earlier. Subsequent prostate biopsy confirmed a prostatic adenocarcinoma, Gleason score 9 (4 + 5).

Oesophageal intramucosal pseudo-diverticulae: diagnosis and investigation of underlying cause

Figure 1 demonstrates the typical pattern of oesophageal intramucosal pseudo-diverticulae (OIP) and a change in calibre with an obstructive filling defect at this level.

False diverticulae, also known as pseudodiverticulae, occur when mucosa and submucosa herniate through a defect in a muscular wall. OIP is a rare condition with a reported incidence of 0.15% in an unselected series of 14 350 barium swallows. The pathogenesis is believed to be an acquired condition with inflammation and stasis as contributory factors. It is hypothesized that blockage of intramural ducts by inflammatory debris or extrinsic compression due to periductal inflammation with fibrosis results in dilation of the submucosal glands.

The majority of patients with OIP have underlying oesophageal strictures or dysmotility. Dysphagia is the presenting symptom in up to 75% of cases and oesophagitis is reported in up to 90% of the patients. Associated strictures, mostly in the upper oesophagus are common. The contrast study in this case demonstrates OIP and a stricture. The tight

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The stricture was post-inflammatory and both pseudo-diverticulae and the stricture itself responded to anti-fungal therapy. The most important differential of the barium findings is oesophageal carcinoma. A higher incidence of OIP has been reported in patients with oesophageal carcinoma (4.5% of 245 patients) compared to 0.9% in a control population. Endoscopic dilation of associated strictures is effective in treating persistent dysphagia. Treatment of the underlying oesophageal disease is mandatory, proton pump inhibitors for oesophageal reflux disease or antifungals for candidiasis.

This case demonstrates the typical radiological features and much rarer endoscopic appearances of oesophageal intramucosal pseudo-diverticulosis. It draws attention to the abrupt onset of symptoms over a number of weeks and the subsequent diagnosis of metastatic prostate carcinoma on further investigation. The importance of an extensive investigation to identify underlying states of immunocompromise associated with OIP is illustrated by this case, as is the necessity for prompt treatment of oesophageal candidiasis.

Conflict of interest: None declared.

References