A young woman with pancreatitis and odynophagia

A 22-year-old woman presented to the hospital with vomiting and epigastric pain. Few weeks back, she underwent laparoscopic cholecystectomy, which was complicated by mild pancreatitis. Following resolution she had gone on vacation and consumed moderate amounts of alcohol. On arrival she was hypotensive and tachycardic. Computed tomography revealed 50% necrosis of the pancreas. She required aggressive management in the intensive care unit. Nine days following admission she remained in severe epigastric pain with inability to tolerate nasojejunal nutrition. This was associated with throat pain and dysphagia. The decision was made to evaluate for the presence of an obstructing calculus in the common bile duct by endoscopy with ultrasonography. No calculus was identified, but endoscopy revealed linear lesions with sloughing of the superficial epithelium throughout the length of the esophagus (Figure 1).

Correlating her clinical and endoscopic findings was consistent with esophagitis dessicans superficiaulis (EDS) which is a rare, benign endoscopic finding characterized by linear fissuring and desquamation of the pale superficial epithelium of the esophagus. Occasionally it can present as emesis of whole esophageal casts. Recent literature has focused on the relationship between EDS and autoimmune bullous dermatitis, but most cases are idiopathic or have diverse associations including bisphosphonates, heavy smoking, celiac disease, esophageal sclerotherapy and critical illness. To our knowledge, this is the first case of EDS associated with acute necrotizing pancreatitis.

EDS is generally a self-limiting condition as esophageal mucosa regenerates after resolution of the primary insult, but has been associated with death in severely debilitated patients. Proton pump inhibitors are the mainstay therapy. In clinical pathologic study of 12 cases of EDS, the use of proton pump inhibitor has been associated with complete resolution of the disease in four out of five patients that returned for follow-up endoscopy.

Our patient was started on a 2-week course of a proton pump inhibitor and managed symptomatically. Her discomfort was exacerbated by the presence of a nasojejunal tube that was placed for feeding. The symptoms improved with resolution of her pancreatitis and she was discharged home in stable condition.

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References

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