SAINT JOSEPH MERCY HEALTH SYSTEM

Herpes Simplex Esophagitis Masquerading as Reflux Esophagitis

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Introduction

- Herpes simplex esophagitis (HSE), caused by the herpes simplex virus (HSV), is the 3rd most common cause of esophagitis behind gastro-esophageal reflux disease and candida infection (1). It is seen predominantly in hosts with impaired immunity resulting from chemotherapy, transplantation, or HIV infection.

- HSE may result from reactivation of HSV with spread of the virus to the esophageal mucosa by way of the vagus nerve or by direct extension of oral-pharyngeal infection into the esophagus (2). It is most commonly caused by HSV-1 although HSV-2 has occasionally been reported (2,3).

- Patient's usually present with odynophagia and/or dysphagia (3). Lesions are typically found in the lower third of the esophagus and are well circumscribed with a volcano-like appearance.

Case Presentation

History and Exam

- A 78-year-old male with past medical history of CLL, metastatic prostate cancer and MGUS presented with complaints of dysphagia and odynophagia. Treated with empiric fluconazole and scheduled for EGD.

- He was being actively treated with Leuprorelin and Docetaxel for prostate cancer. Creating an immunocompromised state.

- Patient was started on empiric Fluconazole, suspecting Candida esophagitis.

Work Up

- Labs were largely unremarkable. WBC and ANC were within normal limits indicating a stable immunosuppressed state.

- EGD was preformed and findings were consistent with reflux esophagitis. No typical signs of HSE.

- Biopsies were sent to check for opportunistic infections in setting of immunosuppressed state and confirmed HSE

Management

- Treated with Acyclovir for 21 days and scheduled for repeat EGD in 3 months to confirm normalization of the esophagus

Discussion

- Endoscopic findings of HSE have been characterized into type I, II and III by Itoh et al. Types I and II show small punched-out lesions with and without raised margins, respectively (Figure 2). Type III is defined when multiple ulcers became confluent like a map (5).

- Vesicular lesions are common in the early stages and exudative lesions are present in most cases (6,7). Mucosal necrosis can be seen in the later stages (8).

- Our case is interesting because the endoscopic findings were not typical of HSE as they did not fit into any Itoh classification. The patient was diagnosed with LA grade C reflux esophagitis before pathology confirmed the diagnosis of HSE.

- This case shows us that opportunistic infections should always be considered in immunocompromised patients even if gross endoscopic appearance does not suggest an infectious cause of esophagitis.

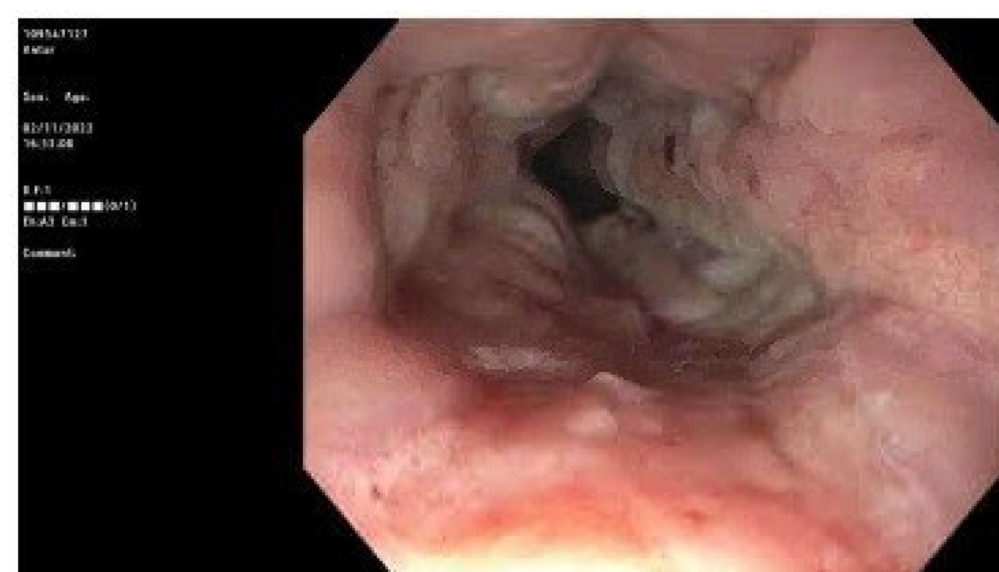

Image 1: Patient's EGD findings, consistent with reflux esophagitis

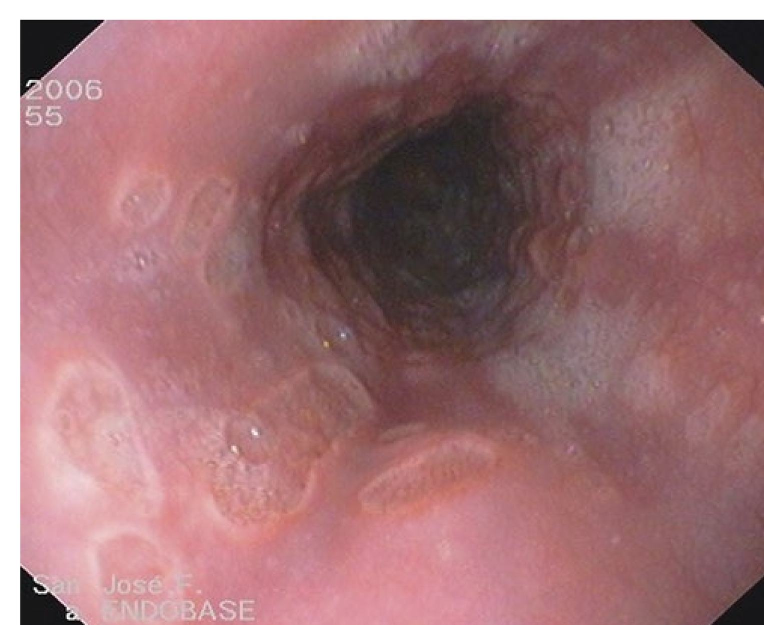

Image 2: Type I and II Itoh classification of HSE. Small punched-out lesions with and without raised margins

References

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