Esophageal intramural pseudodiverticulosis
with food impaction

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Esophageal intramural pseudodiverticulosis is a rare condition of unknown etiology originally described in 1960. It is characterized by multiple, flask-shaped outpouchings of pinhead size in the wall of the esophagus. Very small outpouchings on endoscopy and tiny collections of barium outside of the esophagus wall on esophagography are typical diagnostic findings. During the era of widespread endoscopic and radiological evaluation of esophageal disorders, approximately 200 cases were published in the literature. A 52-year-old man with esophageal intramural pseudodiverticulosis with food impaction is reported. The patient’s symptoms of dysphagia resolved with endoscopic dilations and proton pump inhibitor therapy.

Key Words: Dyspepsia; Esophagus; Pseudodiverticulitis; Schatzki’s ring

CASE PRESENTATION

A 57-year-old man of African descent presented to the emergency room with a food bolus impaction. The patient had been experiencing intermittent solid dysphagia for six months without any prior history of food impaction. The patient denied any heartburn, regurgitation, dyspepsia, abdominal pain and weight loss. He was not taking any prescription or over-the-counter medications. He had a history of alcohol abuse but denied smoking or ingestion of any caustic material. He had laparoscopic sigmoidectomy for stage 3 sigmoid cancer 18 months before presentation with the food impaction, for which he was not taking any counter medications. He had a history of alcohol abuse but denied smoking or ingestion of any caustic material. He had laparoscopic sigmoidectomy for stage 3 sigmoid cancer 18 months before presentation with the food impaction, for which he received six cycles of 5-fluorouracil and folinic acid therapy. A postmortem examination revealed that pseudodiverticula are, indeed, dilated excretory ducts of the esophageal submucosal glands (4,5). Although etiology and pathogenesis of this rare condition have been obscure, obstruction of ducts by inflammatory material, mucus and desquamated epithelium was postulated as the cause of ductal dilation (6). The presence of chronic esophageal inflammation in autopsies of patients with EIPD suggests that this condition may be a sequela of esophagitis (5). Despite esophagitis being relatively common in endoscopic

Pseudodiverticulose oesophagienne intramurale
avec bouchon de nourriture

La pseudodiverticulose oesophagienne intramurale est une affection rare, d'etiologie inconnue, qui a été decrite pour la premiere fois en 1960. Elle se caracterise par une multitude de diverticules de la grosseur d'une tete d'epingle, en forme de fiole, qui se trouvent dans la paroi de l'oesophage. La presence de tres petits diverticules a l'endoscopie et de minuscules amas de baryum a l'exterieur de la paroi de l'oesophage, a l'oesophagographie, est un signe diagnostique caracteristique. A l'epoque ou l'evaluation endoscopique et radiologique des troubles de l'oesophage etait pratique courante, on a fait etat d'environ 200 cas dans la documentation medicale. Voici l'histoire d'un homme de 52 ans, atteint de pseudodiverticuloise oesophagienne intramurale avec bouchon de nourriture. Les symptomes de dysphagie sont disparus par la dilatation endoscopique de l'oesophage et par un traitement aux inhibiteurs de la pompe à protons.

DISCUSSION

Esophageal intramural pseudodiverticulosis (EIPD) is an uncommon condition characterized by flask-like outpouchings with segmental or diffuse involvement of the esophagus and is frequently associated with esophageal radiological narrowing (1,2). In the largest retrospective review of esophageal radiological examinations, this condition was diagnosed in 0.15% of patients (3). EIPD occurs at any age; however, it is most commonly observed in the sixth and seventh decade of life (2). Postmortem examinations revealed that pseudodiverticularia are, indeed, dilated excretory ducts of the esophageal submucosal glands (4,5). Although etiology and pathogenesis of this rare condition have been obscure, obstruction of ducts by inflammatory material, mucus and desquamated epithelium was postulated as the cause of ductal dilation (6). The presence of chronic esophageal inflammation in autopsies of patients with EIPD suggests that this condition may be a sequela of esophagitis (5).
practice, it is unknown why EIPD is so rare. Our patient started to have dysphagia after chemotherapy, but we have not identified any literature on the etiological correlation between chemotherapy and EIPD. EIPD has been reported with gastroesophageal reflux, strictures, webs, herpes or candida esophagitis and esophageal neoplasm (2,3,7,8). Although esophageal motility disorders, such as irregular tonic contractions, tertiary contractions and aperistalsis are commonly reported (2), the causative correlation is not clear. Dysphagia is the most common symptom, which may be acute or chronic (9,10). The most effective therapy is dilation of strictures and treatment of esophagitis.

Our knowledge of the long-term outcome of this condition is limited. On rare occasions, pseudodiverticula have disappeared, but in the majority of cases, visible pseudodiverticula persisted despite symptomatic relief (9,10). Although EIPD has been traditionally viewed as a benign condition, a retrospective review of esophagograms at Tulane University (Louisiana, USA) revealed a significantly higher prevalence of this condition in patients with esophageal carcinoma (11).

In summary, the present report describes a patient with diffuse EIPD who presented with food bolus impaction due to Schatzki’s ring. His dysphagia completely resolved with endoscopic dilations and acid suppression with proton pump inhibitor therapy, but his EIPD persisted. It appeared that his dysphagia was secondary to Schatzki’s ring and EIPD was an incidental finding. There is likely no cause and effect relationship between both conditions, but both of them probably share a similar cause – gastroesophageal reflux disease.

REFERENCES