GE J Port Gastrenterol. 2012;19(5):259–262

Jornal Português de Gastrenterologia
Portuguese Journal of Gastroenterology
www.elsevier.pt/ge

CLINICAL CASE

Eosinophilic esophagitis and refractory heartburn: Case report and review of literature

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Received 9 October 2010; accepted 15 December 2010
Available online 31 July 2012

KEYWORDS
Eosinophils;
Esophagitis;
Gastro-esophageal reflux disease;
Asthma;
Fluticasone

Abstract Eosinophilic esophagitis is an inflammatory condition in which there is dense eosinophilic infiltration of the esophageal lining epithelium. The adult form has only recently gained recognition as a distinct entity. Because of the reflux-type symptomatology, it is commonly misdiagnosed and treated as severe gastroesophageal reflux disease before an appropriate diagnosis is made. We herein present a case of an asthmatic young woman in whom eosinophilic esophagitis was suspected based on symptoms of gastroesophageal reflux disease refractory to standard medical therapy. Biopsies taken from esophageal normal appearing mucosa were essential to establish the diagnosis. She was successfully treated with swallowed fluticasone.

As clinical and pathologic features of gastroesophageal reflux disease and eosinophilic esophagitis may overlap, proper diagnosis requires a keen index of suspicion. Increased awareness of eosinophilic esophagitis is necessary, since treatment with topical steroids may be more effective than acid suppression.

PALAVRAS-CHAVE
Eosinófilos;
Esofagite;
Doença do refluxo gastroesofágico;
Asma;
Fluticasona

Esofagite eosinofílica e azia refratária: relato de caso e revisão da literatura

Resumo A esofagite eosinofílica constitui uma condição inflamatória em que ocorre exuberante infiltração do epitélio esofágico por eosinófilos. No adulto, apenas recentemente foi reconhecida como uma entidade distinta. Devido à semelhança clínica, é muitas vezes confundida e tratada como a doença do refluxo gastroesofágico severa antes do estabelecimento do diagnóstico correto. Apresenta-se o caso de uma doente jovem com asma em quem a esofagite eosinofílica foi suspeitada perante sintomas de refluxo gastroesofágico refratários à terapêutica médica *standard*. A obtenção de biopsias da mucosa esofágica com aspeto endoscopicamente normal foi essencial para o estabelecimento do diagnóstico. A doente foi tratada com sucesso com fluticasona deglutida.

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0872-8178/$ – see front matter
http://dx.doi.org/10.1016/j.jpg.2012.04.024

Como as características clínicas e anatomo-patológicas da doença do refluxo gastroesofágico e da esofagite eosinofílica poderão sobrepor-se, o diagnóstico requer um elevado grau de suspeita. Torna-se assim necessária a crescente sensibilização para esta entidade, já que a corticoterapia tópica poderá ser mais eficaz do que a supressão ácida.

Introduction

Eosinophilic esophagitis is an increasingly recognized cause of atypical chest pain and heartburn that does not respond to aggressive anti-reflux therapy. It is best known in the pediatric population, but its recognition in adults has increased over the past 10 years.

The cause of eosinophilic esophagitis is poorly understood, but allergic and immune-mediated mechanisms similar to those of asthma are implicated.[1]

Eosinophilic esophagitis is defined as a clinicopathologic entity, combining clinical data on (1) relevant symptoms (distinct in the pediatric or adult populations, with mostly food impaction and dysphagia in adults and feeding intolerance, failure to thrive and gastroesophageal reflux disease (GERD) symptoms in children and adolescent); (2) esophageal biopsies with adequate histologic findings (≥20 eosinophils/ high-power field); and (3) exclusion of other diseases with overlapping features, especially GERD.[1]

Endoscopic examination of the esophagus may reveal furrows, corrugations, rings, whitish plaques, *crêpe-paper* like appearance and a small-caliber esophagus. Demonstration of marked eosinophilic infiltration in the esophageal epithelia is the diagnostic hallmark and biopsies should be taken even in normal-appearing mucosa if clinical suspicion is high.

Optimal treatment remains unclear.[2] Swallowed fluticasone, proton pump inhibitor and avoidance of dietary and airborne allergens may be helpful in some patients. Available data suggests that eosinophilic esophagitis runs a benign course, albeit with relapses and need of re-treatment.

We herein present a case of eosinophilic esophagitis in young woman with asthma and symptoms of GERD refractory to maximal doses of pump inhibitor. Awareness and a high index of suspicion were essential to establish the diagnosis. Clinical symptoms and esophageal histology improved with swallowed fluticasone.

Case report

A 22-year-old woman with a history of asthma since childhood presented with heartburn. Complaints were worse in recumbent position and after meals. There was no history of vomiting, dysphagia, food impaction or hematemesis. She had no constitutional features such as weight loss, fever or any other symptom suggesting systemic disease.

Physical examination was unremarkable and complete blood counts revealed discrete eosinophilia, with an eosinophilic count of 680/μL (10%) (upper limit of normal = 500/μL (6%)). There was no anemia, IgE levels were normal and specific IgE to pollens and grass was positive.

An upper gastrointestinal endoscopy was performed and revealed a normal appearing mucosa (Fig. 1). No biopsies were taken and she was diagnosed with non-erosive reflux disease. A 3 month trial with proton pump inhibitors at maximal doses was tried, but heartburn persisted and she began to complaining of intermittent solid-food dysphagia. Esophageal motility study with pH monitoring and barium radiography (Fig. 2) were performed and found to be normal.

Because of persistent heartburn that did not improve with appropriate medical treatment and taking in to account her past asthmatic history, eosinophilic esophagitis was suspected. Upper gastrointestinal endoscopy was then repeated and again revealed normal-appearing mucosa of esophagus, stomach and duodenum. Notwithstanding, biopsies were obtained from the proximal and distal esophagus. Histological examination revealed more than 20 intraepithelial eosinophils per high power field and multiple eosinophilic microabcesses (Fig. 3), both diagnostic of eosinophilic esophagitis. Biopsies from stomach and duodenum were also obtained and histological findings were normal.

The patient was treated with a fluticasone inhaler (four 200 μg puffs twice daily), with instructions to swallow and to rinse her mouth. She also continued treatment with pump-inhibitor (omeprazol 40 mg/day).

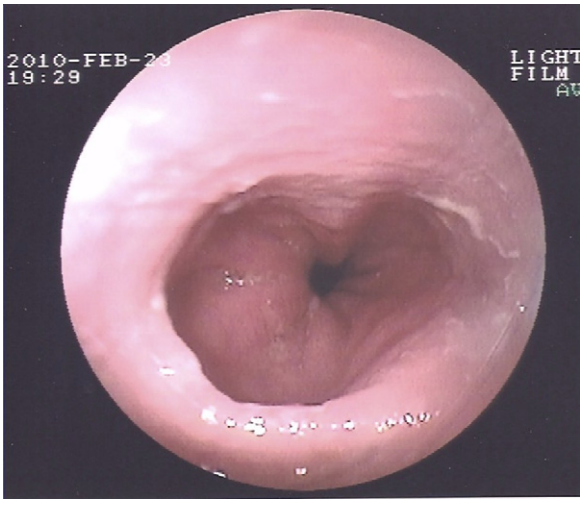

Figure 1 Upper gastrointestinal endoscopy with normal appearing mucosa.