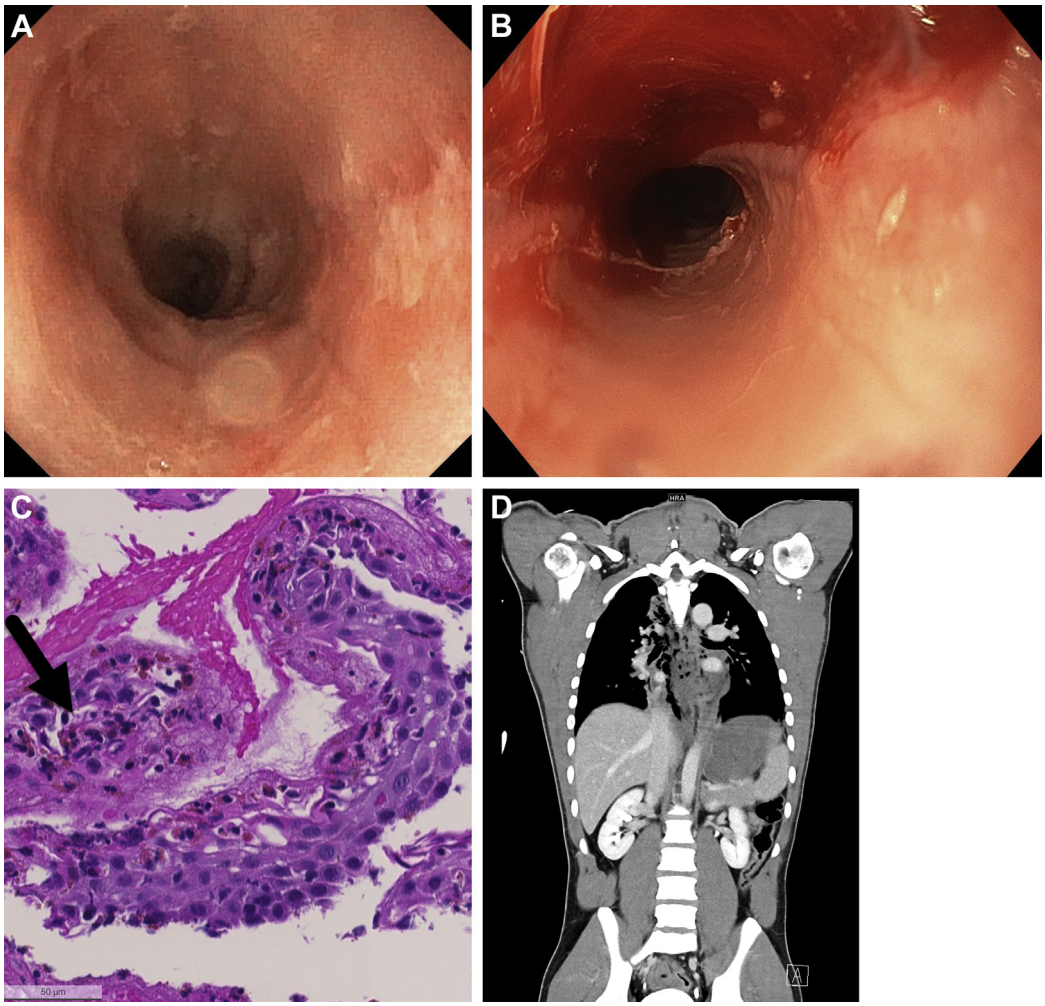
Defer No Time, Delays Have Dangerous Ends (William Shakespeare)

Luc Biedermann,[1] Alex Straumann,[1] and Petr Hruz[2]

[1]Department of Gastroenterology and Hepatology, University Hospital Zurich, Zurich, Switzerland; and [2]Department of Gastroenterology and Hepatology, Clarunis, Basel, Switzerland



Question: A 22-year-old man was diagnosed with eosinophilic esophagitis (EoE) at the age of 9 years in 2007. Already on initial endoscopic presentation, severe stricture formation was described requiring bougie dilation (3 sessions within the first 6 months). Subsequently, treatment with swallowed topical steroids was initiated. After having achieved clinical remission, the patient stopped therapy after 6 months. However, 2 months after withdrawal of steroids, the patient developed a clinical, endoscopic, and histological relapse. Subsequently, the patient was lost to further follow-up, engaging in a sporadic, symptom-guided, and self-directed topical steroid treatment. After almost 10 years without any endoscopic assessment of the disease state, the last endoscopic follow-up antecedent to the current presentation 1 year ago revealed active EoE with edema, furrows, and white exudates (Figure *A*), with long stricture formation in the mid and distal esophagus. The latter precluded passage with a standard gastroscope (outer diameter 9.9 mm), requiring guidewire placement for subsequent dilation to 9 mm using a nasal endoscope (large mucosal tear; Figure *B*). Histology revealed typical EoE characteristics, including eosinophilic abscesses (arrow: proximal esophagus; Figure *C*). Subsequently topical

steroids were reintroduced. Scheduled endoscopic follow-up including repetitive dilation had to be postponed due to Coronavirus Disease 2019 restrictions. Eleven months after last follow-up evaluation, the patient perceived intensive retrosternal pain during ingestion of a meat sandwich. Subsequently, he developed small-volume hematemesis, and immediately called emergency medical services. At the precise moment when the paramedics arrived, the patient had a cardiac arrest with documented asystole. After 4 minutes of mechanical reanimation, spontaneous circulation was restored. In the emergency room, a computed tomography scan was performed (Figure *D*).

What is your diagnosis?

Look on page 44 for the answer and see the *Gastroenterology* website (www.gastrojournal.org) for more information on submitting your favorite image to Clinical Challenges and Images in GI.

Correspondence
Address correspondence to: Luc Biedermann, Department of Gastroenterology and Hepatology, University Hospital Zurich, Zurich, Switzerland. e-mail: luc.biedermann@usz.ch.

Conflicts of interest
The authors disclose no conflicts.

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Answer to Image (Page 42): Esophageal Perforation in the Mid Esophagus With Mediastinitis in Long-standing EoE With Stricture Formation

The computed tomography scan revealed free air in the posterior mediastinum and bilateral pleural effusions. The patient underwent immediate surgery. A rupture of the mid esophagus was identified, with large amounts of residual food in the mediastinum and a soggy consistence of the esophageal tissue. Thus, a decision to resect a large portion of the esophagus was made using an abdomino-thoracic approach with retrosternal gastric pull through and cervical anastomosis. Fortunately, the patient rapidly recovered.

Despite being regarded as a benign chronic-inflammatory disease, EoE harbors several serious complications. This case impressively illustrates that esophageal food impactions frequently occurring in patients with EoE are not simply unpleasant, but sometimes a life-threatening condition. Although EoE nowadays represents the most frequent etiology of emergency room visits due to food impaction, data on associated complications are scarce. Prolonged impaction-to-endoscopy time increases the risk of severe adverse events.[1] Progressive or long-lasting pain in the event of food impaction as well as active and untreated esophageal inflammation are associated with esophageal perforation.[2] Taken together, our case underlines the importance of a consistent treatment and close follow-up of patients with EoE, specifically in those with long-standing and pronounced stricture formation. Albeit rare, esophageal food impaction may evolve into a life-threatening condition with mediastinitis and cardiac arrest due to esophageal perforation. In this case, the near-fatal outcome potentially might have been prevented if follow-up examinations were not postponed. Presumably, during the evolving Coronavirus Disease 2019 pandemia we will be faced with an increase of complications that might at least in part be attributed to delay in providing medical care,[3] including in apparently benign diseases such as EoE.

Keywords: Delay; Eosinophilic Esophagitis; Esophageal Food Impaction; Esophageal Perforation.

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