A previously healthy 34-year-old man presented with severe chest pain, with cough and dyspnea lasting for 2 days. The chest pain had begun after a dinner and the consumption of alcohol, but he denied the ingestion of any foreign body. On physical examination, no palpable mass was observed on the neck, and his lungs were clear on auscultation. His laboratory results at presentation showed significant increases of white blood cells (23.02×10⁹/L), with 90% neutrophils, and C-reactive protein level (180 mg/L). Other tests including serology for cytomegalovirus (CMV) and tuberculosis were within normal limits. A contrast-enhanced computed tomography (CT) scan revealed wall thickening and a low density accumulation in the upper and middle esophagus (Fig.1). Endoscopic examination revealed a longitudinal bulge at 20–30 cm distal to the incisors (Fig.2). The patient was prescribed ciprofloxacin 400 mg intravenously; however, he complained of a fever and chills 2 days later. A three-dimensional reconstruction technique was used to facilitate diagnosis and characterize the esophageal lesion (Fig.1). Endoscopic examination revealed a longitudinal bulge at 20–30 cm distal to the incisors (Fig.2). The patient was prescribed ciprofloxacin 400 mg intravenously; however, he complained of a fever and chills 2 days later. A three-dimensional reconstruction technique was used to facilitate diagnosis and characterize the esophageal lesion (Fig.1). Notably, repeat endoscopy showed pus flowing from a fistula at the upper part of the bulge, consistent with a diagnosis of esophageal abscess (Fig.4a). With the patient under general anesthesia, an endoscopic incision was performed from the fistula to the end of the bulge using an insulated-tip knife (Fig.4b; Video 1). This endoscopic mucosal incision released a large amount of pus and the esophageal wall was intact. Postoperatively, both the patient’s condition and laboratory tests immediately improved. The intramural esophageal abscess was no longer visible on endoscopy or CT examination 3 days postoperatively. On further endoscopy examination, 1 month later, the esophageal longitudinal ulcer from the incision was found to have healed (Fig.4c). Spontaneous esophageal abscess remains a rare event caused by the longitudinal separation of the esophageal mucosal and submucosal layers [1]. Prompt diagnosis and early therapy are needed to prevent death and prolonged serious illness (Fig.5); the key to the diagnosis is an awareness of its frequent atypical presentations. In clinical settings, mucosal injury due to either iatrogenic etiology or foreign body ingestion can often help to identify an intramural esophageal abscess [2]; however, in a healthy and strong young man with no underlying etiology, the diagnosis may be challenging. Three-dimensional reconstruction provided valuable help with the diagnosis in this case and the endoscopic finding of pus from the fistula was highly suggestive of an esophageal abscess. Finally, endoscopic mucosal incision is the...
treatment of choice for an intramural esophageal abscess.

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Competing interests

The authors declare that they have no conflict of interest.

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Video 1 Treatment of an intramural esophageal abscess by endoscopic mucosal incision.

▶ Video 1

Fig. 5 Schematic diagram of the possible outcomes of an intramural esophageal abscess showing: a incision of the mucosa, leading to the release of pus from the abscess, and eventual healing of the ulcer; b possible esophageal perforation and fistula formation, when the intramural esophageal abscess extends into the surrounding tissues, that might result from a delay in diagnosis and intervention.