

Crohn's disease of the esophagus without inflammatory activity confirmed by the use of endoscopy with narrow-band imaging

Crohn's disease of the esophagus is uncommon. Better diagnostic tools, more frequent use of upper endoscopy, and careful histologic examination are probably the causes of the reported higher frequency of proximal Crohn's disease over the past decade [1–2].

We report the case of a 24-year-old female patient who presented to the emergency department with severe abdominal pain, bloody diarrhea, peripheral articular pain, and fever. She had no symptoms of esophageal disease (dysphagia or odynophagia). Upper gastrointestinal endoscopy revealed an extensive excavated lesion in the distal esophagus, measuring 4 cm in the longitudinal axis, covered by cicatricial tissue and with elevated margins. Some pseudodiverticula were also observed in the mid and distal esophagus but no evidence of inflammatory activity was macroscopically demonstrated (● Fig. 1a).

Narrow-band imaging also showed no increased vascularity (● Fig. 1b) [3–4]. Endoscopic ultrasound with a 12-MHz probe showed hypoechoic and homogeneous thickening of the first to fourth layers of the esophageal wall in the site of the ulcerated lesion, without perilesional lymph nodes (● Fig. 2) [5].

We repeated the upper gastrointestinal endoscopy at 6 and 12 months, and the endoscopic and histologic aspects remained the same.

We have to keep in mind all the differential diagnoses of esophageal ulcerated lesions in patients with Crohn's disease: infectious (cytomegalovirus, herpes simplex virus, typical and atypical mycobacteria, fungus) neoplastic, peptic, drugs (biphosphonates, ferrous sulfate, non-steroidal anti-inflammatory drugs), and idiopathic ulcer related to the human immunodeficiency virus. Clinical history and histologic features can help us to differentiate these entities.

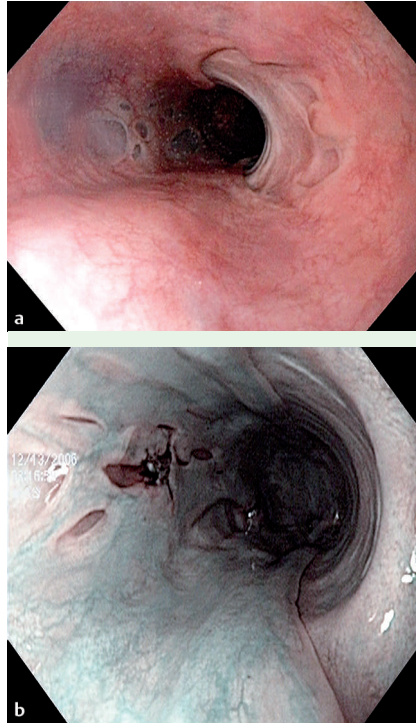


Fig. 1 Upper gastrointestinal endoscopy demonstrated an extensive excavated lesion in the distal esophagus, measuring 4 cm in the longitudinal axis, covered by cicatricial tissue and with elevated margins. Some pseudodiverticula in the mid and distal esophagus were also observed (a), with no evidence of inflammatory activity by narrow band imaging (b).

After establishing a probable diagnosis of Crohn's disease of the esophagus using endoscopic, histologic, and radiologic features, it can still be difficult to determine the activity of these lesions. The use of narrow band imaging can help us to distinguish between the active inflammatory process and cicatricial tissue in this setting.

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AZ

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Fig. 2 Endoscopic ultrasound showed hypoechoic and homogeneous thickening of the first to fourth layers of the esophageal wall in the site of the ulcerated lesion.

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DOI 10.1055/s-0029-1214686
Endoscopy 2009; 41: E188

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