A 75-year-old man was admitted to our department with abdominal pain, hema-
temesis, and melena. His significant med-
ical history included erosive gastritis, al-
cohol-related chronic liver disease, and chron-
ic pancreatitis. He was not receiving 
any medication. His blood pressure was 
low (80/50 mmHg); results of laboratory 
testing showed macrocytic anemia and 
 liver dysfunction (hemoglobin 11.8 g/dL, 
mean cell volume [MCV] 106.4 fL, interna-
tional normalized ratio [INR] 1.53). After a 
second episode of hematemesis, his he-
moglobin dropped to 8.9 g/dL and he was 
treated by infusion of a colloidal solution, 
two units of packed red blood cells, a pro-
ton pump inhibitor, and terlipressin (2 mg 
every 4 hours).

Endoscopy showed a black mucosa
(● Fig. 1a) that started from the upper esophagus and ended abruptly at the cardia. At that level, we identified an ulcer ex-
tending circumferentially in which there was a large exposed vessel (● Fig. 1b), which was treated by application of a Hemoclip. The stomach and duodenum were intact. Brushings were negative for 
cytomegalovirus. Broad-spectrum anti-
biotics, antifibrinolytic drugs, and parenter-
tal nutrition were commenced; terli-
pressin was stopped.

Endoscopy at day 8 showed a clear margin between the intact proximal esophagus and the damaged middle third of the esophagus (● Fig. 2a). The lum-
inal circumference decreased cranio-
caudally, ending in a stricture at the cardia (● Fig. 2b). At day 16, the distal esophagus appeared stenotic but was pas-
sable and enteral nutrition was resumed. The patient was discharged 25 days after admission. A month later, endoscopy revealed almost complete restoration of the mucosa. Notably, at the cardia we ob-
served a Schatzki ring (● Fig. 3). A further
doscopy 8 months later showed no abnormal esophageal findings.

Acute esophageal necrosis is character-
ized by a circumferential mucosal black-
ening involving the distal esophagus and occasionally extending upstream that stops abruptly at the gastroesophageal junction [1]. Ulceration of the cardia, as in this case, is uncommon; however, sim-
ilar cases have been reported [2]. Ischemia, impaired mucosal defenses, and chemical insult seem to contribute to its pathogenesis [3]. The distal esophagus has been shown to be less vascularized in angiographic studies [2,3], arguably making it susceptible to local hypoper-
fusion caused by low splanchnic blood flow. In the case described, such a state could have resulted from hemorrhage and hypotension.

Furthermore, because of the signs of liver dysfunc-
tion and the history of alcohol abuse, which suggested variceal bleeding, the patient received terlipressin, a splanchnic vasoconstrictor that may have reduced microcirculatory perfusion, fur-
ther contributing to the local ischemia [4]. Although cutaneous necrosis follow-
ing terlipressin treatment has been re-
ported [5], this is the first reported case of a possible association with acute esophageal necrosis.

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AH

Competing interests: None
Konstantinos Efthymakis, Chiara Massacesi, Angelo Milano, Francesco Laterza, Emanuele Tafuri, Francesco Cipollone, Matteo Neri
Department of Medicine and Ageing Sciences, Section of Internal Medicine and Center for Excellence on Ageing (Ce.S.I.), “G. D’Annunzio” University and Foundation, Chieti, Italy

References

Bibliography
Endoscopy 2014; 46: E279–E280
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
Matteo Neri, MD
U.O. di Gastroenterologia ed Endoscopia Digestiva
Università G. D’Annunzio
Ospedale SS Annunziata
Chieti
Italy
Fax: +39-0871-357446
mneri@unich.it