A 33-year old male patient was referred to the endoscopy unit because of heartburn and dysphagia lasting for 6 weeks. Symptoms improved only slightly after 4 weeks’ treatment with pantoprazole. No information was available regarding his medical history or medication intake. Endoscopy revealed a pale esophageal mucosa with multiple small white spots, predominantly in the distal esophagus (Fig. 1). Cardia, stomach, and duodenum were normal. A biopsy specimen of the esophagus showed an increased number of eosinophils (peak count 150 per high power field [hpf]), concentrated within the surface epithelium, which is compatible with the presence of eosinophil microabscesses (Fig. 1). The symptoms suggestive of esophageal dysfunction, together with the pathological findings of eosinophil-predominant inflammation led to the diagnosis of eosinophilic esophagitis. Eosinophilic esophagitis is a clinicopathological diagnosis based on the presence of symptoms associated with esophageal dysfunction combined with biopsy findings of eosinophil-predominant inflammation. Common clinical presentations in adults are dysphagia, food impaction, refractory heartburn, central chest pain that is not responsive to antacids, and upper abdominal pain. It is a disease affecting all age groups, with a male predominance [1 – 3].

Typically, endoscopy reveals esophageal rings (so-called trachealization or feline esophagus) and longitudinal furrows as presented in Fig. 2 (from a patient with long-standing episodes of recurrent food impaction and dysphagia, and a peak eosinophil count of 110/hpf at biopsy). Other endoscopic features include white plaques, strictures, narrowing of the esophagus, and pallor or decreased vasculature [4].

Eosinophil-predominant inflammation on biopsy is generally considered to be present when there is a minimum of 15 eosinophils per hpf on microscopy. It is important to exclude alternative causes of esophageal eosinophilia such as gastroesophageal reflux disease, celiac disease, Crohn’s disease, infection, hypereosinophilic syndrome, achalasia, drug hypersensitivity, vasculitis, pemphigoid vegetans, connective tissue disease, and graft-versus-host disease [5].


Bibliography
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