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Submucosal esophageal abscess evolving into intramural submucosal dissection: A case report

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Abstract

BACKGROUND

Here we report a rare case of submucosal esophageal abscess evolving into intramural submucosal dissection.

CASE SUMMARY

An 80-year-old woman was admitted to our emergency department with a chief complaint of dysphagia and fever. Laboratory tests showed mild leukocytosis and elevated C-reactive protein level. Computed tomography showed thickening of the esophageal wall. Upper endoscopy showed a laceration of the esophageal mucosa and a submucosal mass. Spontaneous drainage occurred, and we could see purulent exudate from the crevasse. We closed the laceration with endoscopic clips. The patient did not remember swallowing a foreign body; however, she ate crabs before the symptoms occurred. We prescribed the patient with antibiotic, and the symptoms were gradually relieved. Two months later, upper endoscopy showed that the laceration was healed, and the submucosal abscess disappeared. However, intramural esophageal dissection was formed. We performed endoscopic incision of the septum using dual-knife effectively.

CONCLUSION

In conclusion, we are the first to report the case of esophageal submucosal abscess evolving into intramural esophageal dissection. The significance of this case lies in clear presentation of the evolution process between two disorders. In addition, we

recommend that endoscopic incision be considered as one of the routine therapeutic modalities of intramural esophageal dissection.

Key Words: Submucosal esophageal abscess; Intramural esophageal dissection; Endoscopic incision; Case report

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Core Tip: We are the first to report the case of esophageal submucosal abscess developing into intramural dissection. The significance of this case lies in clear presentation of the evolution process between two disorders, and we demonstrated that esophageal submucosal abscess is one of the etiologies of intramural esophageal dissection, which is a rare entity.

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INTRODUCTION

Esophageal submucosal abscess is an extremely rare disease caused by mucosal injury to the esophagus but without transmural perforation. It has been rarely reported[1-5]. Intramural esophageal dissection (IED) is also a rare disorder characterized by extensive laceration between the mucosal and submucosal layers of the esophageal wall. Herein, we report a rare case of submucosal esophageal abscess evolving into intramural submucosal dissection.

CASE PRESENTATION

Chief complaints

An 80-year-old woman was admitted to our emergency department with a chief complaint of dysphagia and fever for 14 d.

History of present illness

She also had a sore throat.

History of past illness

She had hypertension and type 2 diabetes.

Personal and family history

No special notes.

Physical examination

On examination, the patient was febrile and tachycardiac.

Laboratory examinations

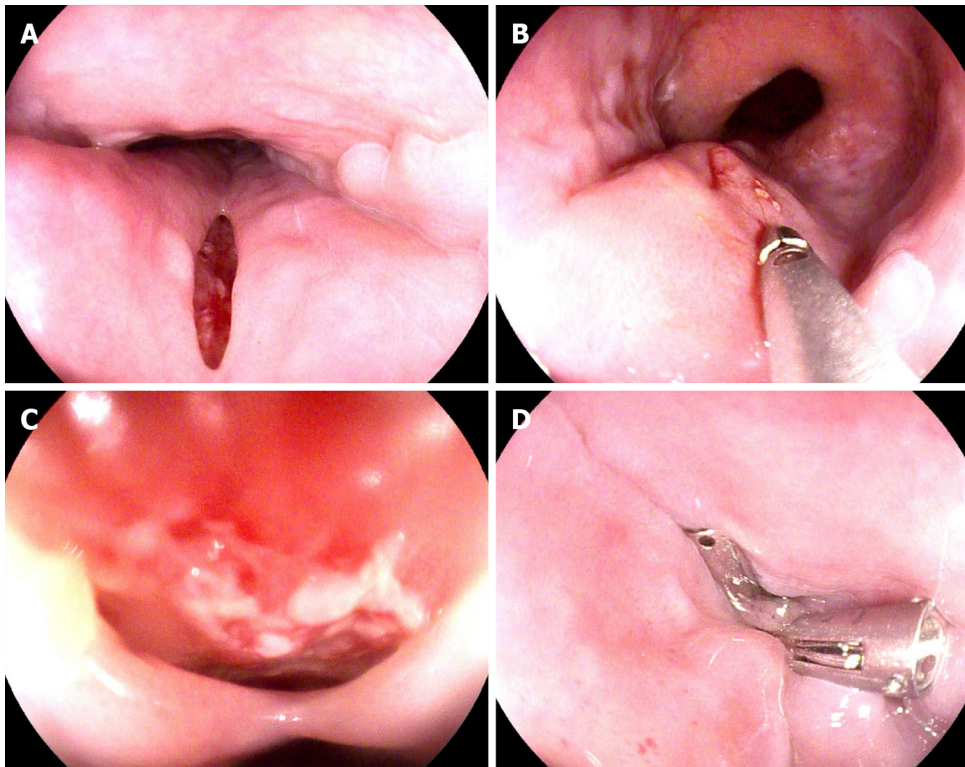
Laboratory tests showed mild leukocytosis and an elevated C-reactive protein level.

Imaging examinations

Chest computed tomography showed eccentric thickening of the esophageal wall.

FINAL DIAGNOSIS

Esophageal carcinoma was our first consideration. To confirm this diagnosis, we performed upper endoscopy, which showed a laceration of the esophageal mucosa 30 cm distal to the incisors and a submucosal mass right above the esophagogastric junction. Spontaneous drainage of the submucosal



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Figure 1 Resolution of the laceration above the mass with metal endoscopic clips. A: 2 cm laceration of the esophagus (30 cm distal to the incisors); B: Submucosal mass was beneath the laceration, with spontaneous rupture; C: Detailed view of the crevasse showing granulated tissues and purulent exudate; D: Laceration was completely closed with metal endoscopic clips.

mass occurred, and we could see purulent exudate from the crevasse. Therefore, the diagnosis of esophageal submucosal abscess was made.

TREATMENT

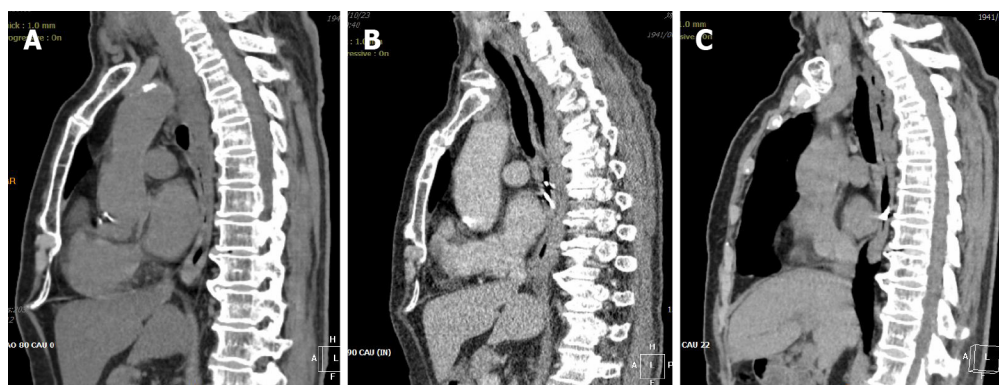
We closed the laceration above the mass with metal endoscopic clips (Figure 1). The patient did not remember swallowing any foreign bodies, but she had eaten crabs before the symptoms occurred. Therefore, we presumed that she might have unintentionally swallowed some crab shell, which caused the laceration of the esophagus. We performed contrast-enhanced chest computed tomography after the endoscopy and found that the thickening of the esophageal wall was worse than before. We prescribed the patient a broad-spectrum antibiotic (sulperazone), and the dysphagia and fever were gradually relieved.

OUTCOME AND FOLLOW-UP

Two months later, we performed chest computed tomography and upper endoscopy again. Computed tomography showed a double-barreled esophagus without thickening of the esophageal wall (Figure 2). Upper endoscopy showed that the laceration had healed, and the submucosal abscess had disappeared. However, an IED formed. Endoscopic incision of the septum between two lumens was performed using a dual-knife process (Olympus, Tokyo, KD650L) with diathermy (Figure 3). An esophagogram taken 3 d after endoscopic incision showed that the barium could pass smoothly through the esophagus, and the dissection had disappeared (Figure 4).

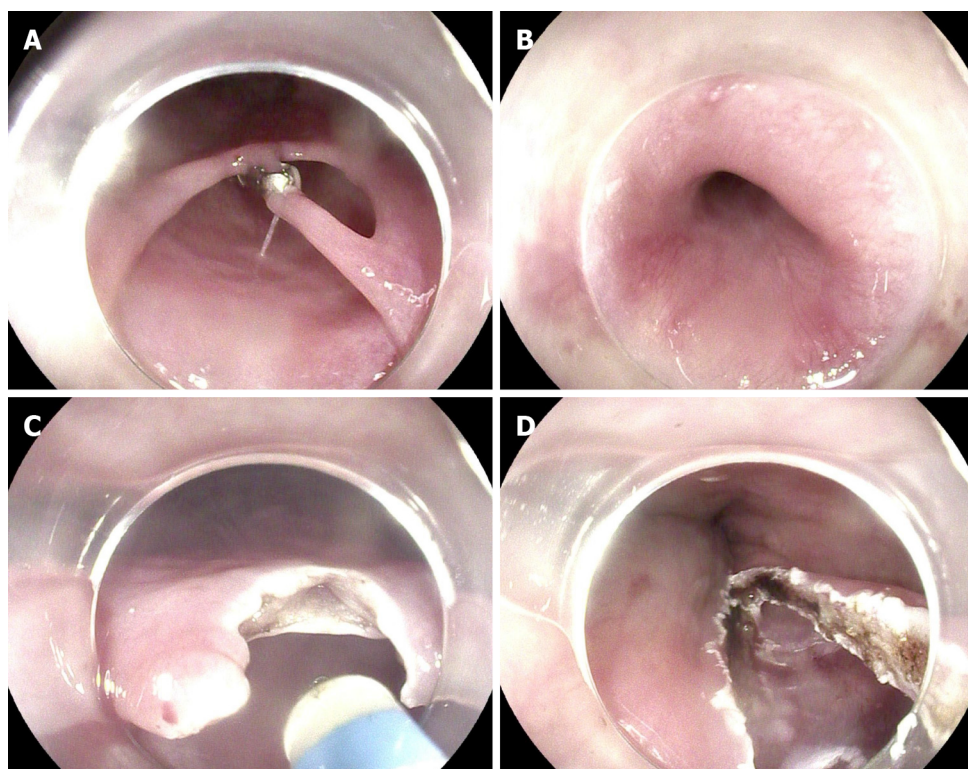
DISCUSSION

Esophageal submucosal abscess is an extremely rare disease caused by mucosal injury to the esophagus but without transmural perforation, which has been reported in very few cases[1-5]. They are often caused by tuberculosis, fish bones, piriform sinus fistulae, and peritonsillar abscesses. In our case, the



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Figure 2 Computed tomography showed a double-barreled esophagus without thickening of the esophageal wall. A: Chest computed tomography scan showed eccentric thickening of the esophageal wall; B: Chest computed tomography scan taken immediately after endoscopy showed worsened diffuse thickening of the esophageal wall; C: Chest computed tomography scan taken 2 mo after endoscopy showed that the thickening of the esophageal wall was alleviated with a double-barreled esophagus visible.



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Figure 3 Endoscopic incision of the septum between two lumens was performed using a dual-knife process with diathermy. A: Intramural submucosal dissection, with one endoscopic clip remaining; B: Internal space of the dissection; C: Endoscopic incision of the septum between two lumens; D: Completely cut septum.

patient had unintentionally swallowed a foreign body that injured the esophageal mucosa and caused subsequent submucosal abscess.

In the present patient, the diagnoses of esophageal submucosal abscess and IED were both made by endoscopy and computed tomography. This case is quite unique in that spontaneous rupture of the abscess occurred, which allowed sufficient drainage. Although the submucosal abscess was cured with broad-spectrum antibiotics, an intramural dissection formed after 2 mo. This case is the first to allow any research team to witness the entire development of the condition as it transitioned from esophageal submucosal abscess to IED. This rare type of IED was confirmed to be the result of a submucosal abscess, establishing that esophageal submucosal abscess is one of the etiologies of IED.

IED is a rare disorder characterized by extensive laceration between the mucosal and submucosal layers of the esophageal wall. It was first reported by Marks and Keet in 1968[6]. The pathogenesis of



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Figure 4 Esophagogram taken 3 d after endoscopic incision showed the dissection had disappeared, and the barium passed smoothly through the esophagus.

IED remains unclear, however two theories have been proposed. The first theory postulates that intramural dissection from submucosal bleeding secondarily tears the mucosa, decompressing the hematoma into the esophageal lumen[7]. The second presumes that the mucosa tears first, with secondary dissection of the submucosa[8]. In rare cases[9], IED is considered to be the result of an intramural abscess caused by a foreign body, as in our patient.

Most teams choose to treat IED with conservative management because of its good prognosis. It is recommended that the patient's regimen should include parenteral nutrition and fasting[10], and reports state that symptoms usually resolve after several days. Surgical treatment is rarely necessary[9]. In our case, the patient was senile and had diabetes mellitus, which rendered her susceptible to various infections. Thus, to avoid food retention and secondary infection, we performed endoscopic incision of the septum with a needle-knife. This endoscopic procedure has been proven to be simple and effective in several cases[11-13]. In rare cases, IED has been treated with self-expandable metal stents and endoscopic dilation[14,15]. Given its safety and effectiveness, we highly recommend endoscopic incision as a routine therapeutic modality for IED.

CONCLUSION

In conclusion, we are the first to report a case of esophageal submucosal abscess developing into intramural dissection. The significance of this case lies in clear presentation of the evolutionary transition between two disorders. We found endoscopic incision of the septum to be a viable therapeutic option for IED.

FOOTNOTES

Author contributions: Jiao Y wrote this article; Sikong YH and Gao PY managed this patient's hospitalization; Ren QG was in charge of the imaging diagnosis; Zuo XL and Zhang AJ made the diagnosis and treatment plan; Li RY performed the operation of this patient.

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