

Dysphagia in an elderly woman with diabetes mellitus: What is your call?

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Cite this article as: Mohan P, Munisamy M. Dysphagia in an elderly woman with diabetes mellitus: What is your call? *Turk J Gastroenterol* 2020; 31(8): 607.

QUESTION

A 65-year-old woman presented with dysphagia for solids and pain during swallowing for 3 months. She had recurrent oral ulcers and burning sensation in her mouth for more than 1 year. There was no vomiting, regurgitation, or gastrointestinal bleeding. Her appetite and weight were stable. She had diabetes for 10 years; she was on oral hypoglycemic

drugs with good glycemic control. Her laboratory findings showed mild anemia and normal renal and liver functions. She underwent a contrast study of the esophagus (Figure 1a) and upper gastrointestinal endoscopy (Figure 1b). Biopsies were taken from the oral lesions (Figure 1c).

What do the Figures A, B, and C show? What is your diagnosis?

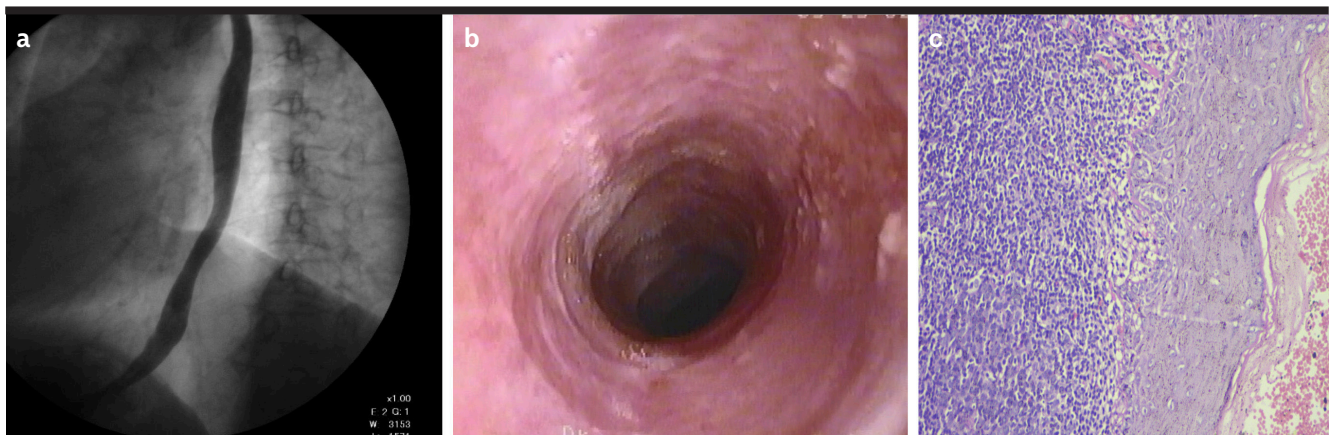


Figure 1. a-c. a) Contrast esophagogram showing narrow-caliber esophagus; Figure b) upper gastrointestinal endoscopy showing several ring-like constrictions with white mucosal plaques; and c) histopathology showing dense lymphocytic infiltration and basal vacuolar degeneration with Civatte bodies.

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Received: **June 7, 2019** Accepted: **July 9, 2019**

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DOI: **10.5152/tjg.2020.19449**

ANSWER

Contrast esophagogram (Figure 1a) showed a narrow-caliber esophagus. Endoscopy (Figure 1b) revealed several ring-like constrictions with white mucosal plaques. Histopathology (Figure 1c) of the oral lesions showed basal vacuolar degeneration with Civatte bodies and dense lymphocytic infiltration in the subepithelium suggestive of lichen planus (LP). The final diagnosis was esophageal involvement in the LP. Her symptoms significantly improved with oral corticosteroids and endoscopic dilatation of the stricture in the proximal esophagus.

DISCUSSION

Lichen planus is a chronic inflammatory disorder of unclear etiology affecting the skin, nails, mucosal surfaces, or genitalia. The oral cavity and skin are most commonly affected. Esophageal LP (ELP) is not uncommon as was previously considered. It is seen in over one-fourth of the patients with asymptomatic oral LP when they are screened for involvement of the esophagus (1-3).

ELP has often been described in elderly women, whereas no such gender preponderance is observed in patients with cutaneous LP (1). The onset of symptoms of dysphagia and odynophagia in ELP may precede the oral or cutaneous manifestations. There is often a delay of months to years before the diagnosis of ELP is made (4). Endoscopy findings are more often observed in the proximal esophagus and include mucosal friability, pseudomembrane, white plaques, superficial erosions, ulceration, webs, rings, strictures, and small-caliber esophagus (2). Contrast esophagogram in ELP shows a small-caliber esophagus and segmental strictures involving the proximal esophagus (5).

Gastroesophageal reflux disease (GERD) and bullous disorders of the skin may commonly cause symptoms similar to ELP and need to be excluded. The endoscopic findings in ELP are predominantly observed in the upper esophagus in contrast to the lower esophageal involvement in GERD (2). The histology of ELP is highly variable and hence nonspecific. They generally mimic the findings seen in oral LP. The presence of a dense band of lymphocytic infiltrate in the lamina propria, basal epithelial degeneration, and necrotic keratinocytes (Civatte bodies) are diagnostic (2).

ELP results in chronic pain and stricture without treatment. There is no consensus regarding the management of ELP, which often would require a multidisciplinary approach. Systemic therapies, including steroids, cyclosporine, azathioprine, and retinoids, have all shown benefit after 1 to 2 weeks of treatment. Patients with definite esophageal strictures and higher grades of dysphagia require endoscopic dilatation in addition to medications (2). ELP has been associated with an increased risk for squamous cell cancer and may require endoscopic surveillance (2). It is, therefore, important to have a high index of suspicion and follow-up of the patients with ELP.

Informed Consent: Written informed consent was obtained from the patient who participated in this study.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept - P.M.; Design - P.M., M.M.; Supervision - P.M., M.M.; Resource - P.M., M.M.; Materials - P.M.; Data Collection and/or Processing - P.M., M.M.; Analysis and/or Interpretation - P.M., M.M.; Literature Search - P.M.; Writing - P.M., M.M.; Critical Reviews - P.M., M.M.

Conflict of Interest: The authors have no conflict of interest to declare.

Financial Disclosure: The authors declare that this study has received no financial support.

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