MCQ 1:

Answer: Herpes simplex esophagitis

MCQ Explanation:
Herpes simplex virus-1 (HSV-1) is the second most common cause of infectious esophagitis after candida in immunocompetent hosts. Patients typically present with symptoms of odynophagia, dysphagia, fever, and retrosternal chest pain. Herpes simplex esophagitis (HSE) may represent reactivation of a latent infection, though it is most often due to a primary infection. Histopathologic confirmation and viral culture are the most effective diagnostic methods for HSE. In our patient, HSV-1 was confirmed by viral culture.

Eosinophilic esophagitis commonly appears as concentric circular rings, termed trachealization of the esophagus, and requires at least 15 eosinophils per high power field on esophageal biopsy. White mucosal plaque-like lesions noted on endoscopy are required for diagnosis of candidal esophagitis, along with the presence of yeast and pseudohyphae on biopsy. Barrett’s esophagus is diagnosed by the presence of columnar epithelium, metaplasia, lining the distal esophagus.

MCQ 2:

Answer: Acyclovir

MCQ Explanation:
HSE is self-limited in the immunocompetent host and typically resolves within 1-2 weeks without treatment. However, treatment with antiviral therapy hastens duration of symptoms and recovery. HSE should be considered in the evaluation of esophagitis of unknown etiology in all immunocompetent individuals, and if diagnosed, HIV should be ruled out. Fluconazole, inhaled corticosteroids, and PPIs do not have a role in the management of HSV esophagitis.

References:

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