Herpes simplex virus esophagitis in the immunocompetent host


OBJECTIVE: The aim of this study was to delineate the characteristics of herpes simplex virus esophagitis (HSVE) in the immunocompetent host.

METHODS: The study entailed a case report and a review of relevant literature through a MEDLINE search back to 1966. All cases with documented HSVE in patients without immunosuppression were selected and their characteristics defined.

RESULTS: A total of 38 cases were identified. The age range was 1-76 yr and the male/female ratio 3.2/1. Antecedent exposure to HSV disease was described in eight cases (21.1%). A prodrome of systemic manifestations preceded the onset of esophageal symptoms in nine subjects (23.6%). Manifestations included acute odynophagia (76.3%), heartburn (50%), and fever (44.7%). Concurrent oropharyngeal lesions were uncommon (n = 8, 21.1%). Endoscopically, extensive involvement was common, showing friable mucosa (84.2%), numerous ulcers (86.8%), and whitish-exudates (39.5%). The distal esophagus was most commonly affected (63.8%). Microscopic examination showed characteristic viral cytopathology in 26 (68.4%) cases. Virus was recovered from esophageal-brushes or biopsies in 23 of 24 (95.8%) patients and immunocytochemistry was positive in seven of eight (87.5%) cases. Immune status was consistent with primary HSV infection in eight (21.1%) cases. The disease was self-limiting, although esophageal perforation and upper GI bleeding were reported in one case each.

CONCLUSIONS: HSVE in the immunocompetent host is a rare but distinct entity, and is significantly more common in male subjects. It represents either primary infection or reactivation, and is characterized by acute onset, systemic manifestations, and extensive erosive-ulcerative involvement of the mid-distal esophagus. Histopathological examination alone may miss the diagnosis; adding tissue-viral culture optimizes the diagnostic sensitivity. It is usually self-limiting; whether antiviral therapy is beneficial remains unknown.

Treatment:
The treatment proposal of our infectiologists was i.v. Aciclovir 5mg/kg body weight for 10 days; as soon as the patient can take the medication by mouth, the regimen can be switched to Valaciclovir 500mg twice daily.