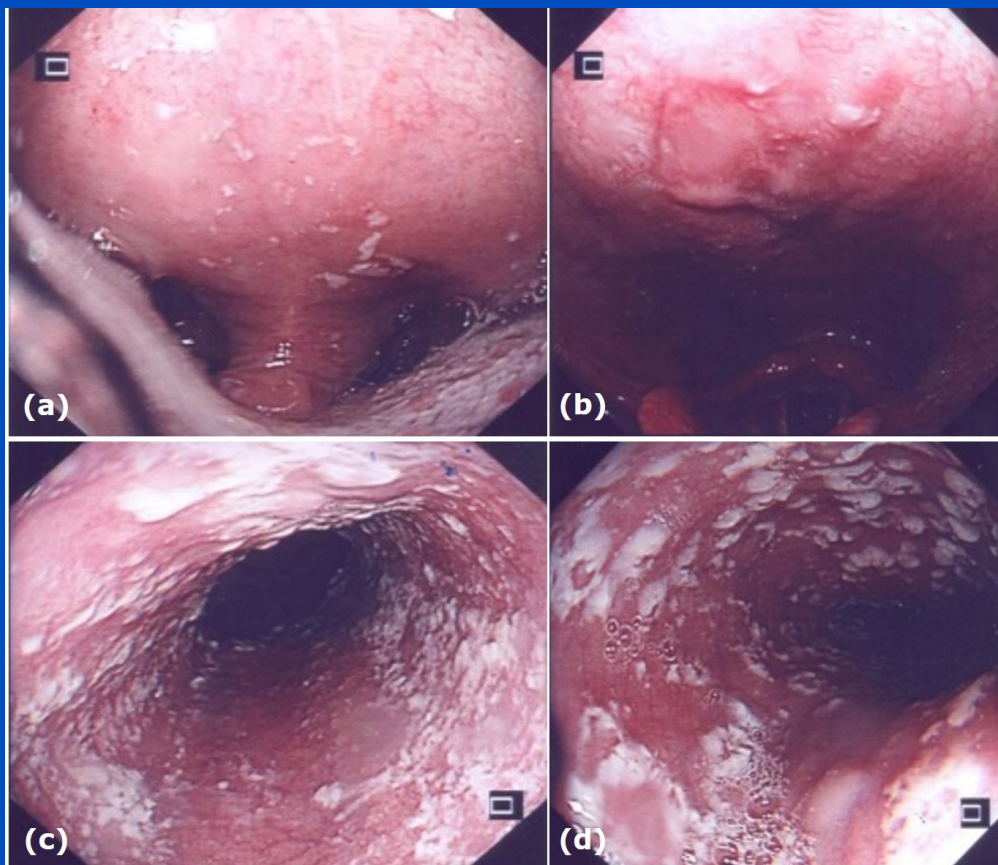


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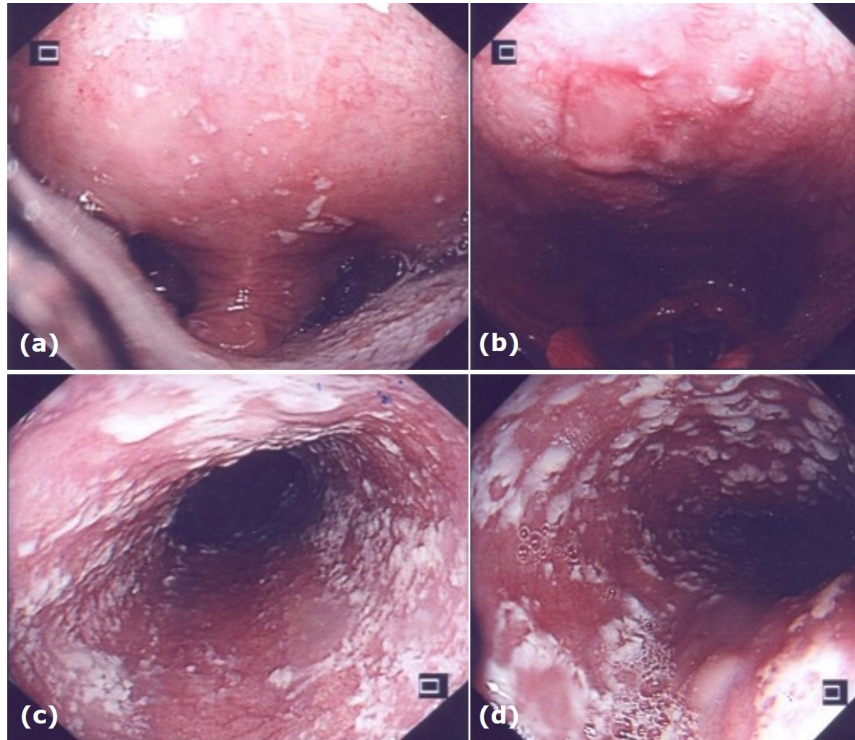


Figure 1

A 62-year-old man presented with reduced appetite. His past medical history included alcohol related liver cirrhosis, hypertension, dyslipidemia, type II diabetes mellitus, and treated *Helicobacter pylori* infection. Physical examination was normal apart from mild pedal edema. There were no other stigmata of liver disease. On ultrasound study of abdomen confirmed the presence of liver cirrhosis. A surveillance endoscopy was performed and showed esophageal varices. In addition, in Figure 1, whitish patches were also seen on the soft palate (a), pharynx (b) and the esophagus (c and d).

What is the diagnosis?

Answer: refer to page [9](#)

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DISCLOSURE: There is no conflict of interest and consent has been obtained from the patient for use of these images.

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(Refer to page 8)

ANSWER: EXTENSIVE ORO-PHARYNGEAL AND ESOPHAGEAL CANDIDIASIS.

Figure 1: a) Whitish patches of candidiasis on the soft palate, b) on the pharyngeal wall, c) proximal esophagus and mid/distal esophagus.

The endoscopic images showed candidiasis affecting the soft palate (a), pharynx (b) and esophagus (c and d). Candidiasis was more diffuse in the esophagus compared to the oral cavity. Apart from reduced appetite, this patient did not complain of dysphagia or odynophagia. He was treated with a ten days course of oral fluconazole.

Esophageal candidiasis, also known as esophageal thrush is due to yeast or fungal infection of esophagus, typically by *Candida albicans*.¹ In most cases, the infection does not cause much specific symptoms and often occurs in association with another illness, hence more common in patients who are admitted for other reasons.² Oral candidiasis is more common than esophageal candidiasis and not infrequently occurs concurrently.

Persons at risk of developing oral and/or esophageal candidiasis are typically immune suppressed either overtly or occultly that can occur from their underlying comorbid conditions (i.e. cancers, significant end stage illness such as liver cirrhosis or kidney failure, diabetes mellitus, acquired immune deficiency syndrome [AIDS] and recent significant illnesses), treatment (i.e. chemotherapy, immunosuppressants such as prednisolone, immune modulators, omeprazole with resultant acid suppression and use of steroid inhalers), use of broad spectrum antibiotics, smokers, dental braces, dry mouth and poor oral hygiene.¹⁻³

Endoscopically, manifestation ranges from scattered to diffuse whitish cheese/curd like patches to confluent involvement with resultant thick white coating, with luminal compromise. The latter is more commonly seen in condition such as AIDS. In AIDS, co-infections with either *cytomegalovirus* or *herpes simplex* esophagitis always need to be considered.⁴

There are no specific symptoms of candidiasis apart from nonspecific symptoms of nausea, vomiting, chest pain, dry mouth, weight loss secondary to reduced oral intake. However, symptom such as dysphagia is common.¹⁻³

Management includes appropriate treatment of chronic disease, control of diabetes, treatment of HIV infection and other immunocompromised disorder, and rational use of antibiotics. Anti-fungal medications like itraconazole, fluconazole and amphotericin B can be used according to severity.¹⁻³

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