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Answer: Oesophageal candidiasis

Oesophageal candidiasis appears as white plaques resembling milk curd that can be scraped off leaving a slightly inflamed base. In severe cases, plagues can be thick and coat the entire length of the oesophagus. In milder cases, it may be confused with food residues or medications. In severely immunocompromised patients such as those with Acquired Immune Deficiency syndrome (AIDS), there may be concomitant infection with Herpes simplex (HSV) and cytomegalovirus (CMV). [1]

Patients may be asymptomatic but most experience anorexia. Other symptoms include odynophagia, dysphagia and burning of the mouth.

Candida yeasts are considered as normal flora in the gastrointestinal and genitourinary tracts of humans. Their growth is control by the host immune system and also by the other commensal bacteria. When an imbalance occurs, this opportunistic ubiquitous species can proliferate resulting in clinically significant manifestations which can be acute, subacute, or chronic or episodic candidiasis. It is commonly referred to as thrush and has been referred to as candidosis, moniliasis, and oidiomycosis. *Candida albicans* is previously known as *Monilia albicans* and *Oidium albicans*.

Apart from the oesophagus, infections can be localised to the mouth, throat, skin, scalp, vagina, fingers, nails, bronchi, lungs or become life-threatening systemic infections such as septicaemia, endocarditis and meningitis. The latter is usually seen in severely immune-compromised patients such as post-transplantation, cancer, post-chemotherapy and AIDS. Apart from this, diseases or conditions linked to candidiasis include mononucleosis, herpes simplex, diabetes mellitus (usually poorly controlled), acid suppressive therapy, recent antibiotic use, steroids (including steroid inhalers), stress, prior gastric surgery, oesophageal motility disorders and nutrient deficiencies. [2, 3]

Candidiasis can be treated with removal of precipitants (i.e. acid suppression and antibiotic use) for mild cases or with antifungal drugs, either topical (cream, suppository or douches), oral or intravenous. For oropharyngeal candididasis, it can be treated with oral or topical antifungal such as clotrimazole, fluconazole, ketoconazole and nystatin. When the infection becomes invasive, more potent (more toxic) antifungal (amphotericin B, caspofungin or variconazole) may require. Candida oesophagitis usually requires systemic therapy with a 7 to 10 days course of fluconazole (100 mg daily). [1]

REFERENCES

1: Pappas PG, Kauffman CA, Andes D, et al. Clinical practice guidelines for the management of candidiasis: 2009 update by the Infectious Diseases Society of America. Clin Infect Dis 2009; 48:503.

2: Underwood JA, Williams JW, Keate RF. Clinical findings and risk factors for Candida esophagitis in outpatients. Dis Esophagus. 2003; 16:66-9.

3: Weerasuriya N, Snape J. A study of candida esophagitis in elderly patients attending a district general hospital in the UK. Dis Esophagus. 2006; 19:189-92.