International Journal of Clinical Science and Medical Research

ISSN(print): 2770-5803, ISSN(online): 2770-582X

Volume 06 Issue 01 January 2026

DOI: https://doi.org/10.55677/IJCSMR/V6I1-01/2026, Impact Factor: 8.005

Page No : 01-04

Herpetic Esophageal Ulcer in an Immunocompromised Host

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ABSTRACT

Herpetic esophagitis is a rare condition that occurs predominantly in immunocompromised patients. Diagnosis is based on the macroscopic findings of upper gastrointestinal endoscopy, with confirmation by histopathological examination and molecular testing (PCR). Intravenous acyclovir remains the treatment of choice.

We report a case of an isolated herpetic esophageal ulcer in a patient with Crohn's disease and a newly diagnosed retroviral infection, who was admitted to our department for the initial evaluation of Crohn's disease.

The diagnosis of herpetic esophagitis was suspected in the presence of odynophagia, high-grade fever (39°C), and marked deterioration of the general condition. Upper gastrointestinal endoscopy revealed a solitary superficial ulcer located in the middle third of the esophagus. HIV serology subsequently returned positive.

Histopathological examination and tissue PCR confirmed the diagnosis of herpetic esophagitis. The patient was treated with intravenous acyclovir, with a favorable clinical outcome.

Published Online: January 05, 2026

KEYWORDS:

Crohn's disease – Retroviral infection (HIV) – Esophageal ulcer – Herpes simplex virus.

INTRODUCTION

Herpetic esophagitis is an inflammatory disorder of the esophageal mucosa caused by Herpes simplex virus type 1 (HSV-1). It is a rare opportunistic infection that occurs predominantly in immunocompromised patients, including those with human immunodeficiency virus (HIV) infection, hematologic and solid malignancies, and other immunosuppressive conditions **[20,21].**

Its association with Crohn's disease is uncommon and is most often secondary to immunosuppressive therapies used in the management of inflammatory bowel disease.

Clinically, herpetic esophagitis typically presents with odynophagia, epigastric pain, and in some cases, upper gastrointestinal bleeding. The diagnosis is based on upper gastrointestinal endoscopy, with confirmation by histopathological examination and detection of the virus by tissue PCR.

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Cite this Article: W. Hliwa, N.khaireh. Amoud, A.Alami. Rahmouni, Z. Boukhal, F.Z.El Rhaoussi, M. Tahiri, F. Haddad, A. Bellabah, W. Badre (2026). Herpetic Esophageal Ulcer in an Immunocompromised Host. International Journal of Clinical Science and Medical Research, 6(1), 01-04. https://doi.org/10.55677/IJCSMR/V6I1-01/2026

The aim of this report is to describe a case of herpetic esophagitis in a patient with Crohn's disease and a newly diagnosed retroviral infection (HIV).

CASE REPORT

We report the case of a 43-year-old woman with no significant past medical history who was admitted to our department for the initial evaluation of Crohn's disease, suspected on the basis of chronic watery diarrhea, abdominal pain, and marked deterioration of her general condition.

Laboratory investigations revealed a significant inflammatory syndrome with an elevated C-reactive protein (CRP) level of 100 mg/L, as well as normochromic normocytic anemia with a hemoglobin level of 9 g/dL. Ileocolonoscopy showed an ulcerative colitis. Histological examination revealed a colonic mucosa with globally altered architecture, showing areas of near-normal appearance alternating with ulcerated and remodeled mucosa. The lamina propria was edematous and congested, with a moderate to severe inflammatory infiltrate and the presence of crypt abscesses, findings consistent with inflammatory bowel disease of the Crohn's disease type.

In addition, the patient presented with odynophagia associated with a high-grade fever of 39°C, which prompted

an upper gastrointestinal endoscopy. This revealed a solitary, well-demarcated esophageal ulcer located in the lower third of the esophagus, on an otherwise normal-appearing mucosa, suggesting a non-peptic, specific esophagitis **(Figure 1).**

Given these endoscopic findings, HIV serology was performed and returned positive. Esophageal biopsies were obtained for histopathological examination and for the detection of Herpes simplex virus and cytomegalovirus by tissue PCR.

Histological analysis showed ulcerated esophageal mucosa with cells exhibiting intranuclear inclusions, multinucleation, and chromatin margination, which are characteristic features of herpetic esophagitis **(Figure 2).** HSV PCR performed on esophageal biopsy specimens was positive at 70.5 IU/mL.

In conclusion, the patient was diagnosed with colonic Crohn's disease associated with herpetic esophagitis in the context of HIV infection.

The patient was treated with intravenous acyclovir at a dose of 5 mg/kg every 8 hours for 10 days, in combination with disease-modifying therapy for the retroviral infection and Crohn's disease. The clinical course was favorable, with complete resolution of odynophagia and fever.

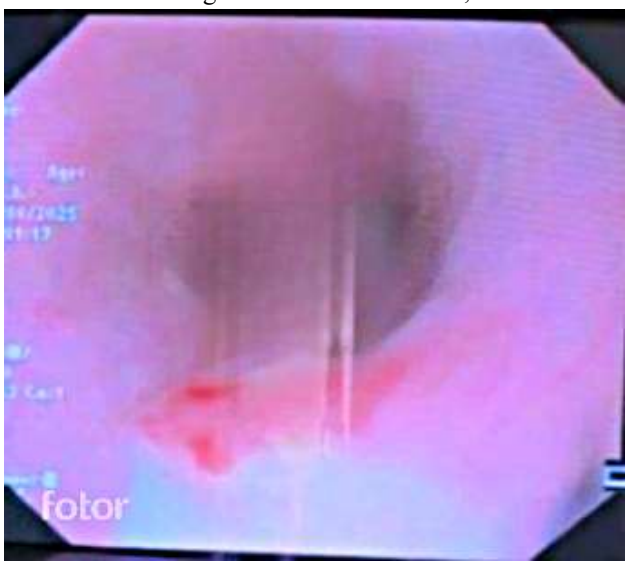

Figure 1: Solitary ulcer located in the middle third of the esophagus.

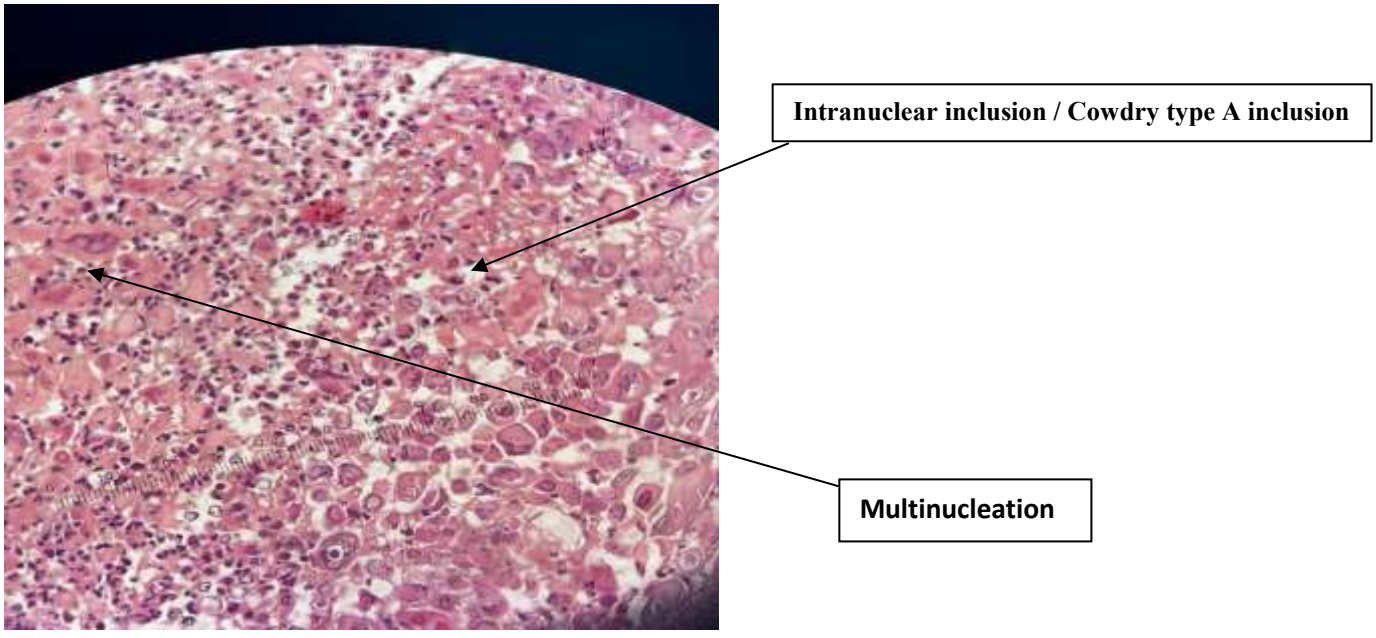

Figure 2: Histological features of herpetic esophagitis.

DISCUSSION

Herpetic esophagitis is a well-recognized complication of immunosuppression, with the esophagus being most frequently involved during disseminated infection by Herpes simplex virus (HSV) [1–3].

In patients with retroviral infection, herpetic esophagitis accounts for 4–16% of esophageal symptoms [5,6]. The incidence of herpetic esophagitis is estimated at 1.8% among immunocompromised patients, with a male predominance in individuals under 40 years of age [23]. In our case, the patient

was a 43-year-old woman with a newly diagnosed HIV infection.

Other predisposing risk factors include gastroesophageal reflux, alcohol abuse, malnutrition, caustic esophageal injury, and eosinophilic esophagitis [24,25].

Although no significant association between inflammatory bowel disease (IBD) and herpetic esophagitis has been demonstrated in the literature, the immunosuppressive therapy used in IBD may predispose patients to opportunistic infections, including herpetic esophagitis.

Clinically, the presentation is dominated by dysphagia, fever, and particularly odynophagia [7,8], as observed in our patient.

Endoscopic examination is essential [9] and may reveal ulcerations, vesicles, and erosions [10,11]. In the literature, the typical location of herpetic esophagitis in immunocompromised patients is the lower third of the esophagus [7], which contrasts with our case, where the lesion was located in the middle third.

Histological examination alone is sufficient to establish the diagnosis of herpetic esophagitis [12,13]. Typical lesions include ballooning degeneration, ground-glass nuclei with margination of chromatin, eosinophilic intranuclear inclusions (Cowdry type A), and multinucleated giant squamous epithelial cells [14].

Polymerase chain reaction (PCR) can be justified when the herpetic nature of an ulcerated esophagitis is not demonstrated histologically [15]. In our case, both histology and PCR confirmed the diagnosis of herpetic esophagitis.

Acyclovir remains the treatment of choice, administered at a dose of 5 mg/kg every 8 hours, most often intravenously due to dysphagia, odynophagia, and vomiting [16,17]. Our patient received intravenous acyclovir at 5 mg/kg every 8 hours for 10 days, with a favorable clinical outcome.

CONCLUSION

Herpetic esophagitis is common in immunocompromised patients and should be systematically considered in the presence of any gastrointestinal symptoms. Histological examination and microbiological testing (PCR) constitute the gold standard for a definitive diagnosis. Acyclovir, administered orally or intravenously, remains the treatment of choice.

REFERENCES

1. Buss DH, Scharyj M. Infection par le virus de l'herpès de l'œsophage et d'autres organes viscéraux chez les adultes. Incidence et signification clinique. *Am J Med* 1979 ; 66 : 457 à 62.
2. Müller SA, Herrmann EC, Winkelmann RK. Infections à herpès simplex dans les hémopathies malignes. *AmJ Med* 1972 ; 52 : 102 à 14.
3. Alexander JA, Brouillette DE, Chien MC, *et al.* Œsophagite infectieuse suite à une transplantation hépatique et rénale. *Dig DisSci* 1988 ; 33 : 1121 à 1126.
4. McDonald GB, Sharma P, Hackman RC, Meyers JD, Thomas ED. Infections œsophagiennes chez les patients immunodéprimés après une greffe de moelle osseuse. *Gastro-entérologie* 1985 ; 88 : 1111 à 117.
5. Gould E, Kory WP, Raskin JB, Ibe MJ, Redlhammer DE. Résultats de la biopsie de l'œsophage dans le syndrome d'immunodéficience acquise (SIDA). *South Med J* 1988 ; 81 : 1392-5.
6. Bonacini M, Young T, Laine L. Les causes des symptômes œsophagiens dans l'infection par le virus de l'immunodéficience humaine. *Arch Intern Med* 1991 ; 151 : 1567 à 1572.
7. Généreau T, Lortholary O, Bouchaud O *et al.* Œsophagite à herpès simplex chez les patients atteints du SIDA : rapport de 34 cas. *Clin Infect Dis,* 1996 ; 22 : 926 à 931.
8. chemin McBane, J.B. Gross. Herpès œsophagite : syndrome clinique, aspect endoscopique et diagnostic chez 23 patients. *Gastrointest Endosc* 1991 ; 37 : 600 à 603.
9. Galbraith JC, Shafran SD. Œsophagite à herpès simplex chez le patient immunocompétent : rapport de quatre cas et revue. *Clin Infect Dis,* 1992 ; 14 : 894 à 901.
10. Matsumoto J, Sumiyoshi A. Œsophagite à herpès simplex - une étude dans une série d'autopsies. *Am J Clin Pathol* 1985 ; 84 : 96 à 99.
11. Baehr PH, McDonald GB. Infections œsophagiennes : facteurs de risque, présentation, diagnostic et traitement. *Gastro-entérologie* 1994 ; 106 : 509 à 532.
12. Shah SM, Schaeffer RF, Araoz A. Diagnostic cytologique de l'œsophagite herpétique. Un rapport de cas. *Acta Cytol* 1977 ; 21 : 109 à 11.
13. Cardillo MR, Forte F. Cytologie au pinceau dans le diagnostic de l'œsophagite herpétique. Un rapport de cas. *Endoscopie* 1988 ; 20 : 156 à 157.
14. Feiden W, Borchard F, Bürrig KF, Pfitzer P. Herpès œsophagite. I. Investigations microscopiques et immunohistochimiques légères. *Arc de Virchows (Pathol Anat)* 1984 ; 404 : 167 à 176.
15. Greenson JL, Beschorner WE, Boitnott JK, Yardley JH. L'infiltrat proéminent de cellules mononucléées est caractéristique de l'herpès œsophagite. *Hum Pathol* 1991 ; 22 : 541 à 549.
16. Patel R, Paya CV. Infections chez les receveurs d'une greffe d'organe solide. *Clin Microbiol Rev* 1997 ; 10 : 86 à 124.
17. Walter EA, Bowden RA. Infection chez le receveur d'une greffe de moelle osseuse. *Infect dis Clin North Am* 1995 ; 9 : 823 à 847.

18. Wang HW, Kuo CJ, Lin WR, et al.: Clinical characteristics and manifestation of herpes esophagitis: one single-center experience in Taiwan. Medicine (Baltimore). 2016, 95:e3187.
19. Marinho AV, Bonfim VM, de Alencar LR, Pinto SA, de Araújo Filho JAD: Herpetic esophagitis in immunocompetent medical student. Case Rep Infect Dis. 2014, 2014:930459.
20. Diezma-Martín AM, Gigante-Miravalles E, Castro Limo JD, Quimbayo Arcila CA, Puche Paniagua JJ: Herpetic esophagitis in immunocompentent host: cases report. BMC Infect Dis. 2020, 20:605.
21. Itoh T, Takahashi T, Kusaka K, Kawaura K, Nakagawa Y, Yamakawa J, Kanda T: Herpes simplex esophagitis from 1307 autopsy cases. J Gastroenterol Hepatol. 2003, 18:1407-11.
22. Généreau T, Rozenberg F, Bouchaud O, Marche C, Lortholary O: Herpes esophagitis: a comprehensive review. Clin Microbiol Infect. 1997, 3:397-407.
23. Lavery EA, Coyle WJ: Herpes simplex virus and the alimentary tract. Curr Gastroenterol Rep. 2008, 10:417 23.
24. Hoversten P, Kamboj AK, Katzka DA: Infections of the esophagus: an update on risk factors, diagnosis, and management. Dis Esophagus. 2018, 31:doy094.
25. Sousa B, Silva J, Araújo E, Costa R, Calheiros A: Herpetic esophagitis: a cause of dysphagia in a malnourished patient. Cureus. 2023, 15:e43858.