Esophageal biopsies were consistent with Candida esophagitis. Repeat endoscopy for re-treatment was completed 2 days later and diffuse severe mucosal changes consistent with pseudo-diverticulosis were found (Figure 2). The esophageal stricture (Figure 3) was found again and dilation was performed to 45Fr. She completed a 1 month course of fluconazole. Repeat endoscopy one month later showed candida esophagitis and EIPD, but resolution of stenosis.

DISCUSSION: Esophageal intramural pseudodiverticulosis (EIPD) is a rare condition with unclear etiology and pathogenesis, although some theorize that chronic inflammation or motility issues may contribute. It has been associated with diabetes mellitus, HIV, alcoholism, gastroesophageal reflux, candidiasis, infectious esophagitis, achalasia, and other motor disorders. Diagnosis is often made during endoscopy or found on imaging such as barium esophageal studies. Stricture development particularly in upper or mid esophagus can occur in up to 50% of patients. Risk of squamous cell carcinoma has also been reported. Conservative management is the treatment of choice, although endoscopic therapy with bougienage dilation is sometimes required, often with repeat dilation. This case highlights a common complication in an uncommon condition. This patient required repeat bougienage dilation, but it is important to remember treatment of underlying etiology is key.

**Effect of Naloxegol on Opioid-Induced Esophageal Motility Disorder**

**INTRODUCTION:** Effects of Opioid on Gastrointestinal motility are well documented and increasing attention is being paid to their effect on esophageal motility. Spastic Disorders like Achalasia type III, Esophageal Gastric Outlet Obstruction, and Distal Esophageal Spasm are reported with the use of opioids. Decreased incidence has been reported after withholding opioids. Naloxegol is a peripherally acting mu opioid receptor antagonist approved for opioid induced constipation, however it’s effect on Opioid induced esophageal dysmotility are not known.

**CASE DESCRIPTION/METHODS:** We studied 2 patients with opioid induced constipation and concurrent esophageal motility disorders with esophageal high resolution manometry while on Opioids and repeated after placing them on Naloxegol 25 mg daily for 5 days. Studies were interpreted based on Chicago Classification 3.0. Esophageal motility disorder subtype, Distal Contractile Integral (DCI), Integrated Relaxation Pressure (IRP), and Distal Latency(DL) were recorded for each of the 10 water swallows and compared with paired t- test. Case 1. 67 year old male on Oxycodone 30 mg twice daily with Dysphagia. Manometry showed Jackhammer esophagus which converted to normal study with Naloxegol 25 mg po daily with resolution of symptoms. DCI decreased from 10992 mmHgcm to 2359 mmHgcm, (P < 0.05)Case 2. 73 year old female on Oxycodone 10 mg q 6 hours with Dysphagia and regurgitation. Manometry showed Achalasia type III which converted to Type II Achalasia with Naloxegol with significant decrease in regurgitation and mild improvement in dysphagia. DCI decreased from 5901 mmHgcm to 2887 mmHgcm. In both patients there was a significant decrease in DCI after initiating Naloxegol (P < 0.05).

**DISCUSSION:** Naloxegol could successfully decrease DCI in our 2 patient with opioid induced esophageal disorders and change esophageal manometric signatures favorably with improvement in clinical symptoms. Larger studies are needed with different opioids to study and confirm dose-effect relationships.

**Atypical Dysphagia Diagnosis in Young HIV Patient**

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**INTRODUCTION:** A healthy 26-year-old African American male presented to the hospital due to recent history of dysphagia, odynophagia and progressive weight loss. Symptoms began two weeks ago with an episode of choking and occurred both, with solids and liquids. There was no history of asthma, food allergies, eczema, or other skin rashes. He admitted to socially smoking tobacco and drinking alcohol but no illicit drugs. Patient was sexually active with males. Physical examination was grossly unremarkable and laboratory tests were negative for leukocytosis, eosinophilia and anemia, however, his HIV testing was positive (CD4 count 30 cells/mm3). Chest X-ray was unremarkable.

**CASE DESCRIPTION/METHODS:** Patient underwent esophagogastroduodenoscopy (EGD), where a few cratered, punched out non-bleeding esophageal ulcers were noted, 35-37 cm from the mucosal upper with LA Grade C esophagitis. Esophageal biopsy results are as shown in Figure 2. 

**DISCUSSION:** Esophageal biopsies for this patient diagnosed him with lichenoid esophagitis pattern (LEP). LEP is diagnosed in patients who have characteristic pathologic findings of lichen planus esophagitis (LPE) without confirmation with direct immunofluorescence (DIF). Epidemiologically, LEP is generally diagnosed in younger patients than LPE with both diagnoses affecting white females primarily. The predominant symptomatology of LEP is dysphagia. Diagnosis is dependent on esophageal biopsies with most common indication for EGD being dysphagia. Endoscopic evaluation of a patient with LEP will demonstrate mucosa that may be acanthotic and/or atrophic in conjunction to esophagitis, ulcerations, and/or strictures with a predilection for involvement of the mid esophagus. Histologic evaluation will note a pattern of injury composed of mostly lymphocytes affecting the epithelium and lamina propria. Civatte bodies, apoptotic squamous cells, can be seen dispersed throughout the epithelium and should be considered as a diagnostic criterion in biopsy evaluation.

There is a correlation between viral diseases (HIV, hepatitis B/C) and patients diagnosed with LEP although there is not agreement among different opioids to study and conclude on their effects. Spastic Disorders like gastroesophageal reflux disease and achalasia are mainly affecting white females.

**REFERENCES**

[1967] Figure 1. Diffuse atrophic mucosa with numerous non-bleeding ulcerations in mid esophagus.

[1966] Figure 1. Effect Of Naloxegol on Opioid induced disorder.

**Pneumopericardium by Esophageal-Pericardial Fistula of Unknown Origin**

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