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Esophagogastroduodenoscopy-induced angina bullosa hemorrhagica of the pharynx

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A 60-year-old man with a history of hypertension and hyperlipidemia underwent an esophagogastroduodenoscopy (EGD) for further inspection of a small brownish area in the postcricoid area detected during a laryngoscopy. The Valsalva maneuver was attempted using a transoral endoscope with a magnifying function; however, it was difficult to observe the postcricoid area because of a strong gag reflex. After the pharyngeal examination, angina bullosa hemorrhagica (ABH) was observed in the uvula (Fig. 1) and the posterior wall of the hypopharynx (Fig. 2). The patient was followed up conservatively, because the lesions were mild and he was asymptomatic.

ABH is a benign lesion with subepithelial blisters filled with blood and not caused by a systemic or hemostatic disorder [1,2]. Mild trauma is the usual cause of a broken epithelium–connective tissue junction, which results in superficial capillary bleeding [1,2]. The long-term use of inhaled steroids, hypertension, diabetes mellitus, and older age are considered as risk factors [2]. The differential diagnoses may include pemphigus, dermatitis herpetiformis, and bullous lichen planus [2]. Although ABH usually resolves spontaneously, tracheal intubation is required in extreme situations to protect the airway [3]. Therefore, gastroenterologists should be aware of EGD-induced ABH.

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Conflict of Interest: None

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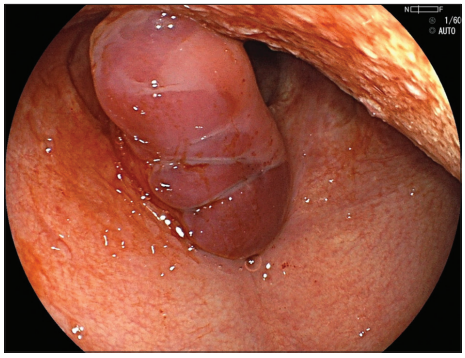

Figure 1 Endoscopic image of esophagogastroduodenoscopy-induced angina bullosa hemorrhagica in the uvula

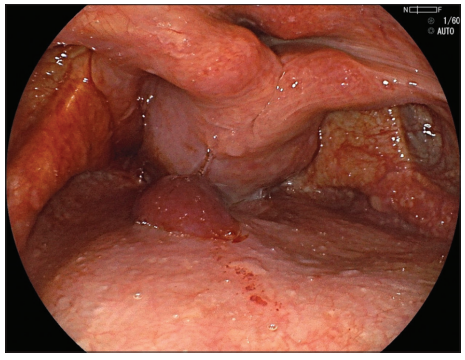

Figure 2 Endoscopic image of esophagogastroduodenoscopy-induced angina bullosa hemorrhagica in the posterior wall of the hypopharynx

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