Introduction: Candida esophagitis is the most common cause of infectious esophagitis, responsible for 88% of all cases, followed by herpes simplex virus (10%) and cytomegalovirus (2%).

Case: A 45-year-old male with past medical history of hypertension, hyperlipidemia, human immunodeficiency virus (HIV) and intravenous drug use (IVDU) presented to the Emergency Department (ED) with 3 days of substernal chest pain. At triage, his EKG was normal sinus with ST depression in the inferior leads with T wave inversion in lead III and aVF, however EKG six hours later was normal sinus with no evidence of ischemia. High sensitivity troponin was 4 on arrival and when repeated (normal 0-20). Initial labs revealed a leukocytosis with no left shift, and were otherwise unremarkable, including BNP, CK, HbA1c, and urinalysis. His physical exam was unremarkable, chest pain was not reproducible, and there were no pharyngeal erythema or tonsillar exudates. He failed to improve following a GI cocktail and pepcid. On further questioning, he described pain in the center of his chest, which was worse with swallowing especially with liquids, and that he could feel the food passing in the center of his chest. EGD demonstrated diffuse candida esophagitis. He improved with oral fluconazole.

Discussion: Esophagitis symptoms typically include dysphagia, odynophagia, or retrosternal chest pain; some patients are asymptomatic. Candida is an opportunistic infection with impaired cell-mediated immunity a major risk factor, which includes HIV, chemotherapy, chronic immunosuppression with steroids, adrenal insufficiency, diabetes mellitus, and advanced age. Esophageal candidiasis has a prevalence of 9.8% in HIV-positive patients, and 0.32-5.2% in the general population. Physical exam will commonly reveal oral thrush, however 18% of patients had no oral thrush in one study, just like this patient. In an immunocompromised patient presenting with odynophagia, it is acceptable to empirically treat with an antifungal such as fluconazole for 14-21 days. If the patient reports no improvement within 3 days, then the patient should undergo esophagogastroduodenoscopy to determine the underlying cause.