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LETTER TO THE EDITOR
ΓΡΑΜΜΑ ΠΡΟΣ ΤΟΝ ΕΚΔΟΤΗ

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ΑΡΧΕΙΑ ΕΛΛΗΝΙΚΗΣ ΙΑΤΡΙΚΗΣ 2024, 41(5):711–712

Schatzki's ring

Schatzki's ring (SR) is a common benign cause of dysphagia associated with hiatal hernia, gastroesophageal reflux, Barrett's esophagus, and eosinophilic esophagitis (EE), and was described for the first time in medical literature by Schatzki and Gary.[1–4] SRs under 13 mm are symptomatic, and those larger than 25 mm are asymptomatic, and a frequent cause of dysphagia for solids affecting adults of both genders. They are estimated to be detected in up to 14% of images in barium radiographic evaluations.[3,4] The symptoms, often related with not well-chewed meat, are usually referred as "food sticking", "lump" or "blockage" between the cricoid and sternal notch, or odynophagia; besides, the expression "steakhouse syndrome" is already enshrined in the literature.[3,4] The target of the SR management is increasing the ring diameter by means of breaking it, utilizing the dilations with bougies or pneumonic balloons, and biopsies of the rings.[3,4] Recurrences may occur (up to 64% in the first two years) needing repeated dilation.[3] It is noteworthy that patients with EE coexistent with esophageal furrows or SR have a higher risk of dysphagia for solids and increased probability to need more invasive treatment.[1] Recently, we read a very illustrative text published in this journal by Skarpas et al,[3] with a useful synthesis of major characteristics of a condition that may develop unsuspectedly. The authors called attention to diverse esophageal disturbances, such as EE, infections, reflux disease, strictures, extrinsic compressions, motility disorders, pill esophagitis, radiation-induced esophagitis, ruptures, and malignancies in the differential diagnosis with SR.[3] The treatment of asymptomatic and incidentally found SR is not needed after endoscopy evaluation to discard other causes of strictures, mainly some esophageal malignancy.[3,4] Aiming to highlight their relevant work, some additional comments are now addressed.

In a study including 291 patients with EE and a mean age of 42 years, the majority had typical linear furrows or concentric rings, while 47% of them presented gastroesophageal reflux disease with the evidence of erosive-esophagitis, besides hiatal hernia and SR.[1] Few patients (15%) had normal endoscopic aspect, and the only change was eosinophilia. The mucosal biopsies revealed a mean eosinophil count per high power field (HPF) per patient of 40.6±26. One or more episodes of dysphagia for solids were registered in 16% of the patients, and the risk of these events was less likely in the absence of the esophageal furrows or rings.[1] The authors commented the need for biomarkers to predict the risk of esophageal food impaction, as well as a clinical scoring system to predict the negative patient outcomes.[1]

In conclusion, the concomitance of SR, EE, hiatal hernia and gastroesophageal reflux can represent a cornerstone factor to be evaluated among this group of patients, through their longstanding specialized follow-ups, aiming to result in better outcomes.

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ΠΕΡΙΛΗΨΗ

Δακτύλιος του Schatzki

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