acquired immunodeficiency syndrome (AIDS). Typical infections encountered are *Candida*, herpes, cytomegalovirus, and human immunodeficiency virus (HIV).

The most common infection of the esophagus is due to *Candida albicans* and it usually occurs in those who are immunocompromised. However, it can be seen in patients with diabetes or from stasis in achalasia. Endoscopically, *Candida* appears as white plaques on a friable and erythematous mucosa. This is seen on double contrast studies as linear or irregular longitudinal filling defects. More fulminant Candidiasis is seen in those with advanced AIDS, causing pseudomembrane formation and large plaques. Radiographically, these appear as a shaggy or foamy esophagus. In the appropriate clinical setting, these radiographic findings alone should be sufficient to initiate antifungal treatment.

**ESOPHAGEAL NEOPLASMS**

Benign tumors comprise approximately 20% of all esophageal tumors and are usually asymptomatic. When they are large, they may create the sensation of dysphagia. Classic benign tumors have well-defined smooth borders, indicating a nonaggressive appearance with leiomyoma being most common. Other tumors of mesenchymal origin, fibrovascular polyps, squamous papillomas, and adenomas are other benign neoplasms that may occur.

The most common types of esophageal carcinoma are squamous cell carcinoma and adenocarcinoma. The clinical presentation is similar, with progressively worsening dysphagia being the most common complaint. This is usually a late finding since the tumor has enlarged to the point of obstructing the esophageal lumen. Tumors are usually advanced upon initial diagnosis owing to the lack of an esophageal serosa, allowing easy spread of the neoplasm.

Adenocarcinoma accounts for 30% to 50% of esophageal carcinoma. Barrett’s esophagus is the predisposing lesion with the transformation of dysplastic columnar cells to carcinoma.