AN UNUSUAL CAUSE OF GASTROINTESTINAL BLOOD LOSS

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INTRODUCTION

Gastric adenomas are relatively rare, estimated to represent 10% of all gastric polyps. [1]

These are classically thought to represent a premalignant phase along the inflammation-dysplasia-neoplasia sequence. [2]

In contrast, foveolar-type adenomas typically arise in areas of relatively unremarkable gastric mucosa and are generally less aggressive than other adenoma subtypes. [3]

These lesions are commonly associated with hereditary tumor syndromes such as familial adenomatous polyposis but can also occur sporadically and are of unclear clinical significance. [4]

We present the case of a newly identified iron deficiency anemia that was found to have a gastric foveolar-type adenoma as a rare cause of GI blood loss.

CASE SUMMARY

A 73-year-old male with granulomatous hepatitis and metabolic syndrome presented for evaluation of IDA.

Endoscopy revealed one 3 mm polyp in the transverse colon, a 15 mm sessile gastric polyp in the cardia with stigmata of bleeding (Figure 1), and a 5 mm sessile polyp with mild central depression in the gastric body (Figure 2). The larger polyp was removed with a hot snare.

Histology revealed that the larger polyp had polypoid low-grade dysplasia consistent with a GFA (Figure 3). The smaller polyp was found to be a well-differentiated neuroendocrine tumor with a Ki-67 Proliferative Index of 5.45%, consistent with grade 2. The singular colonic polyp returned as a simple tubular adenoma.

The decision was made to pursue surveillance endoscopy due to the relatively low proliferative index of the GNET. EGD revealed three 2-4mm sessile polyps with no bleeding and no stigmata of recent bleeding in the gastric body, which were removed with a cold snare.

Surveillance endoscopies were planned for every 6 months thereafter.

FIGURES

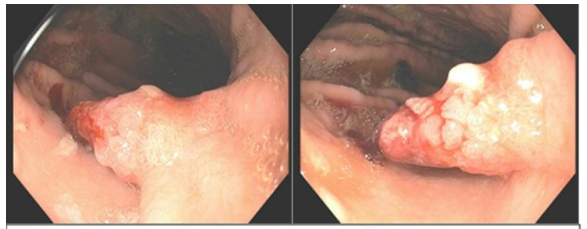

Figure 1. Gastric polyp with raspberry-like appearance located in the cardia. Stigmata of recent bleeding seen.

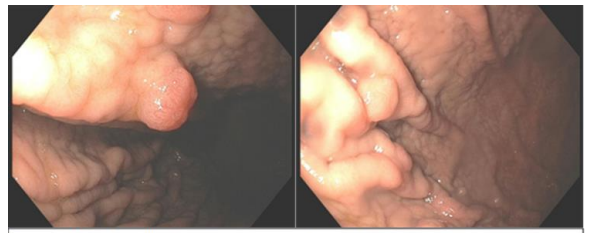

Figure 2. Multiple sessile polyps without stigmata of recent bleeding seen in the gastric body.

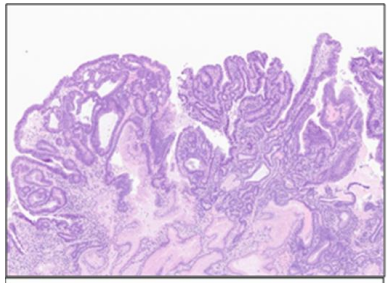

Figure 3. Histology of gastric foveolar-type adenoma showing surface papillary projections lined with foveolar-type epithelium. Surface epithelium with cytoplasmic neutral mucins.

DISCUSSION

Very few cases of GFAs have been reported in the literature [2-5]. Classically, these lesions are associated with hereditary tumor syndromes like familial adenomatous polyposis (FAP) and gastric adenocarcinoma and proximal gastric polyposis (GAPPS) [5]. Additionally, these lesions are typically described as small, flat, or depressed and arise in areas of unremarkable gastric mucosa, rarely resulting in clinically relevant symptoms.

One recent single-center study describes a type of sporadic GFA with a raspberry-like appearance, which the authors theorize to be a subtype of sporadic GFAs [4]. In their study, the lesions were described as small, reddish polyps with granular surfaces, with a mean lesion size of 3.2mm. All lesions were in the upper or middle stomach [4]. A second study by Jian Guan et al describes the 'first case' of a large (2.3cm), protruding GFA in the junction of the gastric body/antrum leading to clinically relevant symptoms of gastrointestinal bleeding [3]. The lesion they identified was described as a broad-based polyp with a papillary or gyrus-like appearance on the surface [3]. From the images included in their study, the lesion appeared pedunculated. Our case describes the first instance of a sporadic moderate-sized sessile gastric foveolar adenoma with a strawberry-like appearance developing in the gastric cardia, causing the clinically relevant symptoms of gastrointestinal bleed.

CONCLUSIONS

- In summary, we presented a unique case of a moderately sized GFA which appeared at the gastric cardia and caused chronic oozing bleed as the main reason for iron-deficiency anemia.
- This case highlights the importance of early endoscopic evaluation of GIB and emphasizes the broad scope of clinical manifestations of GFAs.

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