Collagenous Gastritis: A Rare Cause of Anemia

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INTRODUCTION

One relatively common cause of gastrointestinal symptoms including abdominal pain and diarrhea is microscopic colitis. Much less commonly seen is the related disorder collagenous gastritis, which relies on pathology and high clinical suspicion for diagnosis. We report on a case of a patient with this rare finding.

CASE

A 32-year-old male with a past medical history of achalasia status post myotomy presented with symptomatic normocytic anemia.

His initial work up was significant for a hemoglobin of 5g/dL with reported use of non-steroidal anti-inflammatory drugs.

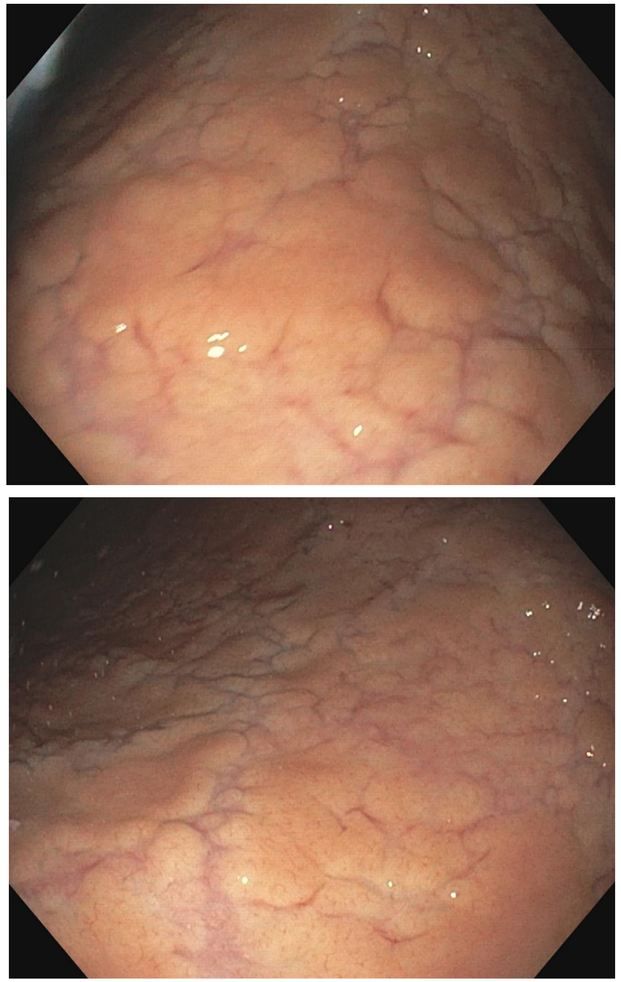
Esophagogastroduodenoscopy showed atypical gastropathy with gross cobblestoning in the gastric body. Pathology from this endoscopy showed chronic gastritis with focal gastric intestinal metaplasia, normal duodenal mucosal biopsies. Celiac disease serology was also negative.

Repeat EGD with gastric mapping demonstrated chronic gastritis, no intestinal metaplasia, negative H. pylori. Trichome stain highlighted increased subepithelial collagen layer which was confirmed by a gastrointestinal pathologist, consistent with collagenous gastritis.

Colonoscopy was normal; colon biopsies were not taken as patient was asymptomatic. He was started on iron supplementation and remains well.

FIGURES 1-2: Endoscopic Findings

Near and far endoscopic findings of cobblestoned collagenous gastritis mucosa.



DISCUSSION

Collagenous enteritides are a class of gastrointestinal disorders encompassing collagenous colitis, sprue, and gastritis. While collagenous colitis is relatively common, collagenous gastritis remains very rare.

Typical symptoms include abdominal pain, nausea, diarrhea, and anemia. The most common endoscopic findings include gastric nodularity in the gastric body, erosions, and erythema.

The diagnosis depends on pathologic findings of subepithelial infiltration with chronic inflammatory cells in the lamina propria, as well as deposition of collagen bands greater than 10 microns in thickness.

The pathogenesis remains unclear, but medications like NSAIDs as well as smoking have been implicated. It is also associated with several autoimmune diseases including Sjogren's and ulcerative colitis, causing postulation that there may be overexpression of HLA DR by epithelial cells and CD25 positive cells.

There is currently no established therapy, and management is usually supportive care. Our case highlights the importance of a high level of suspicion for this rare disease, and pursuit of accurate diagnosis in the face of clinical perplexity. Likely etiology in our case appears to NSAIDs use which is known trigger for collagenous colitis.