Deep biopsy via endoscopic submucosal dissection for primary gastric amyloidosis

Amyloidosis is characterized by interference with multiple organs. It is usually systemic and uncommonly limited to the stomach [1, 2]. Here we report a rare case of primary gastric amyloidosis.

A previously healthy 56-year-old man, whose family history was not significant for any digestive system tumors or blood disorders, presented to our institution with dyspepsia and weight loss lasting for one year. Esophagogastroduodenoscopy (EGD) showed multiple depressed superficial lesions at the greater curve of the gastric body (▶ Fig. 1a). The lesions were whitish, and the boundaries were not clear. Gastric cancer and malignant lymphoma were suspected initially, but biopsy specimens revealed mild chronic atrophic gastritis. Notably, the lesions bled easily after biopsy, so we used endoclips (▶ Fig. 1b). To rule out any missed diagnosis and misdiagnosis, we decided to perform a deep biopsy via endoscopic submucosal dissection (ESD) with informed consent. After evaluation of endoscopic ultrasonography (EUS) and magnification endoscopy with narrow band imaging, we removed one of the lesions en bloc in a specimen measuring 300 × 270 mm (▶ Video 1). Unexpectedly, histopathological examination showed deposition of amyloid in the mucosal and submucosal layer (▶ Fig. 2a) with the ability to bind Congo red (▶ Fig. 2b), leading to green birefringence under polarized light (▶ Fig. 2c). Furthermore, light chain staining for kappa and lambda were positive. Additionally, we performed an enteroscopy and biopsies from the esophagus, duodenum, jejunum, ileum, and colon, all of which were negative for amyloid. Meanwhile, the patient received a systematic examination including blood biochemistry analysis, coagulation test, echocardiography, abdominal computed tomography (CT), serum-free light chain analysis, and protein electrophoresis, yet no abnormalities were found. Because other organs were unaffected, we diagnosed gastric amyloidosis and endoscopic surveillance was arranged.

In conclusion, primary gastric amyloidosis remains challenging to diagnose because its appearance on endoscopy is not specific [3, 4]. However, when facing suspicious lesions, we endoscopists should be aware of amyloidosis and investigate further.

Video 1 Deep biopsy via endoscopic submucosal dissection for primary gastric amyloidosis.

Funding

Supported by the National Natural Science Foundation of China, http://dx.doi.org/10.13039/501100001809 82070575
Competing interests
The authors declare that they have no conflict of interest.

The authors
Zheng Zhao¹, Yue Jiao¹, Bing Yue², Wenjing Wang¹, Guiping Zhao¹, Shutian Zhang¹, Peng Li¹
1 Department of Gastroenterology, Beijing Friendship Hospital, Capital Medical University, Beijing, China
2 Department of Pathology, Beijing Friendship Hospital, Capital Medical University, Beijing, China

Corresponding author
Peng Li, MD, PhD
Beijing Friendship Hospital, No. 95 Yong'an Road, Xicheng District, Beijing 100050, China
lipeng@ccmu.edu.cn

References

Bibliography
Endoscopy
DOI 10.1055/a-1493-2081
ISSN 0013-726X
published online 2021
© 2021. Thieme. All rights reserved.

Endoscopy E-Videos
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

Fig. 2  Histopathologic findings. a Hematoxylin and eosin staining shows deposition of amyloid in the mucosal and submucosal layer. b Congo red staining reveals amyloid deposition with orange-colored deposits in the mucosal and submucosal layer. c Green birefringence under polarized light.