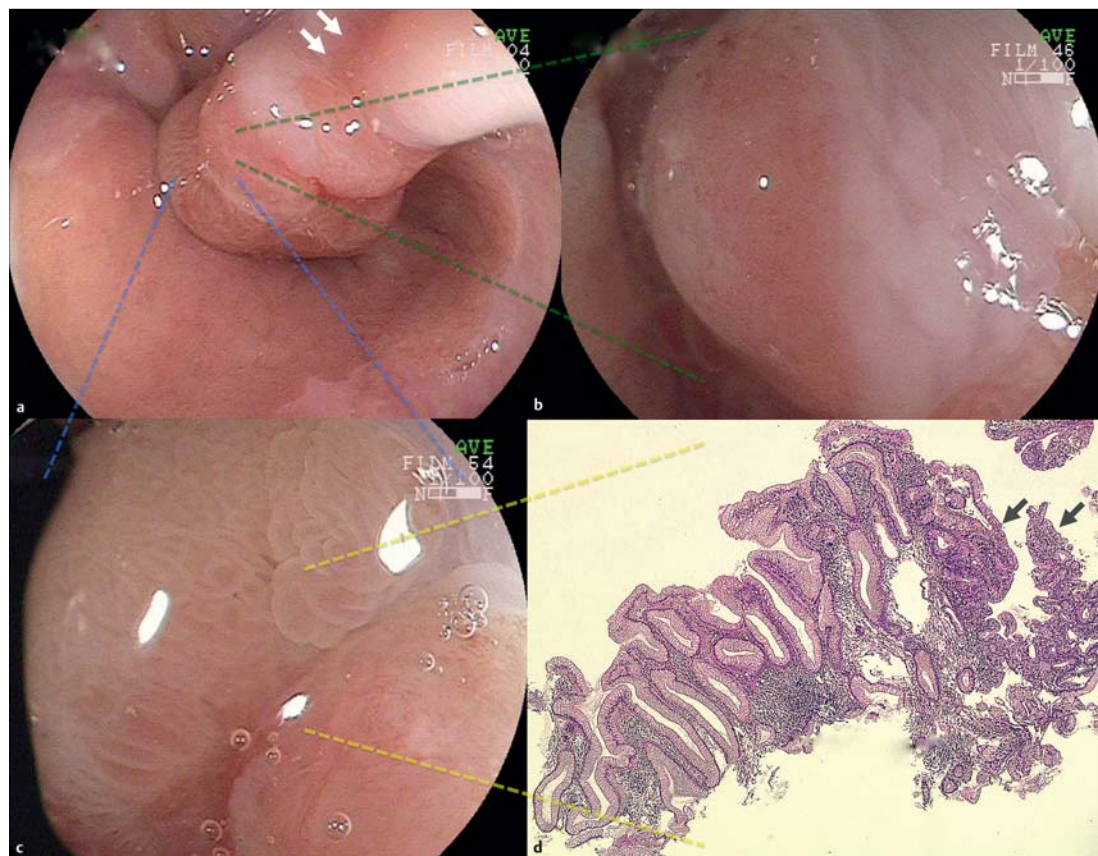


## Complete disappearance of an esophagogastric polyp with concurrent early-stage adenocarcinoma after administration of a proton pump inhibitor



**Fig. 1** **a** Endoscopic view showing a reddish elevation on an esophagogastric polyp and evidence of gastroesophageal reflux disease (arrow). **b** Magnifying endoscopy showing features of squamous epithelium on the oral side of the polyp. **c** On the anal side, magnifying endoscopy revealed foveolar hyperplasia, while the central region had an amorphous pit pattern with irregular arrangement of microvessels. **d** Histological section of the biopsy specimen confirming hyperplasia of the foveolar epithelium and infiltration of inflammatory cells with granulation tissue in the lamina propria on the anal side of the polyp without epithelial and stromal atypia (lower right), and adenocarcinoma (arrow) in the center of the polyp.

A 42-year-old woman with early-stage cancer of the esophagogastric junction was admitted to our hospital for treatment. Ambulatory endoscopic examination revealed a round, elevated lesion, 6 × 5 mm in size, with a reddish surface on top of a 2-cm polyp (● **Fig. 1**) and evidence of gastroesophageal reflux disease (GERD). Magnifying endoscopy showed that the lesion mostly had an amorphous pit pattern with irregularly arranged microvessels in the central area. Histological examination of a biopsy specimen confirmed the presence of an inflammatory esophagogastric polyp with concurrent adenocarcinoma. The patient was prescribed a proton-pump inhibitor (PPI; lansoprazole 30 mg/day) and an endoscopic examination after 1 month revealed that the polyp had completely disappeared and the residual lesion was stage 0 – IIa + IIc (● **Fig. 2a**). Endoscopic mucosal resection using a cap (EMR-C) was successfully carried out (● **Fig. 2b**).



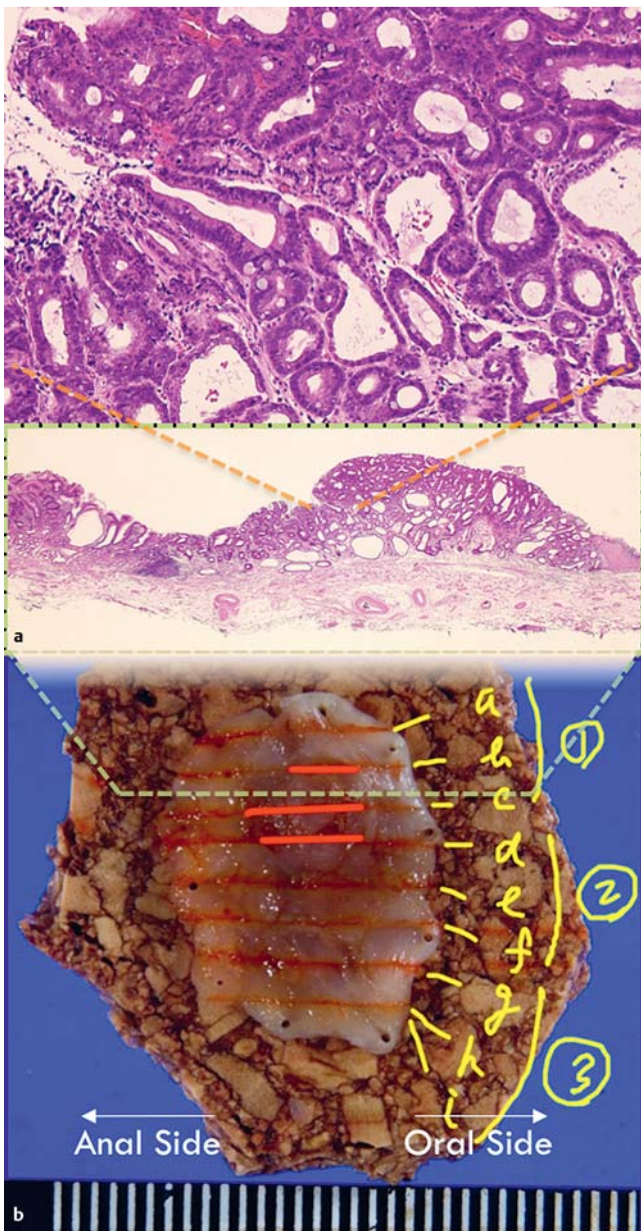
**Fig. 2** **a** Endoscopic view after 1 month of lansoprazole treatment showing complete disappearance of the inflammatory polyp.



**Fig. 2** **b** The lesion was treated by endoscopic mucosal resection with a cap (EMR-C).

Histological examination of the resected specimen showed a well-differentiated adenocarcinoma in situ without vascular invasion (● **Fig. 2c**); complete resection of lateral and vertical margins was confirmed.

Endoscopically, a short segment of Barrett esophagus was noted in the surrounding mucosa, but it was not clear whether there was any relation between the Barrett epithelium and the carcinoma. There was no recurrence or evidence of metastasis during a follow-up period of 5 years.



**Fig. 2** c Photomicrograph (hematoxylin and eosin) and macroscopic view and of the endoscopic mucosal resection (EMR) specimen showing adenocarcinoma with a raised surface on the oral (esophageal) side and slightly depressed surface on the anal (gastric) side (a). The paraffin slices (b) (1a–c; 2d–f; 3g–i) examined histologically are indicated.

An inflammatory esophagogastric polyp is characterized endoscopically as a hyperplastic or/and squamous polyp arising at the esophagogastric junction and histologically as foveolar or/and squamous epithelium with inflammatory changes [1,2]. It is thought that this lesion is closely associated with inflammation of the esophagogastric junction, such as GERD in the present case, and it is treated effectively with a PPI. Here, we describe for the

first time a rare case of adenocarcinoma occurring concurrently with an inflammatory esophagogastric polyp, which completely disappeared after administration of a PPI. Cases with only adenocarcinoma showing inflammatory esophagogastric polyplike appearance and cases of inflammatory polyp with bizarre stromal cells, “pseudomalignant erosion”, at the esophagogastric junction have been reported previously [2–5], but simulta-

neous occurrence of adenocarcinoma on an inflammatory esophagogastric polyp has not been reported. In such cases, it is thought that administration of a PPI aids confirmation of diagnosis of esophagogastric junctional carcinoma and that magnifying endoscopy is useful for demarcating the lesion prior to endoscopic resection.

Endoscopy\_UCTN\_Code\_CCL\_1AB\_2AC\_3AB

**T. Yoshida<sup>1</sup>, Y. Shimizu<sup>1</sup>, J. Hirota<sup>1</sup>, Y. Ono<sup>1</sup>, M. Nakagawa<sup>1</sup>, S. Ono<sup>2</sup>, S. Nakagawa<sup>1</sup>, M. Kato<sup>2</sup>, M. Asaka<sup>1</sup>**

<sup>1</sup> Department of Gastroenterology, Hokkaido University Graduate School of Medicine, Hokkaido, Japan

<sup>2</sup> Division of Endoscopy, Hokkaido University Hospital, Hokkaido, Japan

## References

- 1 Bleshman MH, Banner MP, Jonson RC et al. The inflammatory esophagogastric polyp a fold. *Radiology* 1978; 128: 589–593
- 2 Styles RA, Gibb SP, Tarshis A et al. Esophagogastric polyps: Radiographic and endoscopic findings. *Radiology* 1985; 154: 307–311
- 3 Nino-Murcia M, Friedland GW. A characteristic “Inflammatory polyp” at the esophagogastric junction that was a cancer. *Am J Roentgenol* 1988; 150: 948–949
- 4 Dirschmid K, Walser J, Hugel H. Pseudomalignant erosion in hyperplastic gastric polyps. *Cancer* 1984; 54: 2290–2293
- 5 Moriyama T, Matsumoto T, Jo Y et al. Pseudomalignant erosion in an inflammatory polyp at esophagocardial junction. *Gastrointest Endosc* 2003; 57: 987–989

## Bibliography

DOI 10.1055/s-0029-1243985

Endoscopy 2010; 42: E176–E177

© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

## Corresponding author

**T. Yoshida, MD**

Department of Gastroenterology  
Hokkaido University Graduate School of Medicine  
Division of Endoscopy  
Hokkaido University Hospital  
Nishi-7, Kita-15  
Kita-ku, Sapporo  
Hokkaido 060-8638  
Japan  
Fax: +81-11-7067867  
peugeot307ccs16@yahoo.co.jp