A 24-year-old man was referred for further evaluation of obscure-occult gastrointestinal bleeding. He had presented 5 years earlier with an episode of acute iron-deficiency anemia at 9.7 g/dL without overt hemorrhage. He was treated by oral iron supplementation, but a low ferritin level persisted at 35 µg/L. He was asymptomatic and used no medication. He was twice explored unsuccessfully by gastroscopy, colonoscopy, and small-bowel follow-through.

A first capsule endoscopy (Pill cam SB 2; Given Imaging, Yoqneam, Israel) showed a sessile polypoid lesion at three-quarters of the small-bowel transit time (Fig. 1). A second capsule endoscopy confirmed the presence of the same lesion at the same location. This time the lesion was visualised inside a cavity (Fig. 2) and a double lumen was seen, suggesting a Meckel’s diverticulum.

No double-balloon enteroscopy was performed due to the need for surgical treatment.

The patient underwent single-port laparoscopy and a Meckel’s diverticulum with a palpable lesion inside was detected (Fig. 3). After resection of a 5-cm-long segment, the diverticulum was opened and a 2-cm sessile polypoid lesion with three superficial erosions was revealed. Histologically, the lesion corresponded to a hypervascularised epithelium of gastric fundic and antral mucosa, with superficial ulcerations, without *Helicobacter pylori* infection (Fig. 4).

In the era of capsule endoscopy, a few cases of Meckel’s diverticulum have been reported where the diagnosis was suggested either because of active bleeding [1, 2] or by the endoscopic aspect of a double orifice [3, 4]. In our patient, we had the additional finding of a polypoid lesion inside the Meckel’s diverticulum that corresponded surprisingly to an ectopic gastric mucosa. There is one more case of an ectopic gastric mucosa detected by capsule endoscopy [5]; however these are the first images where close visualization has been achieved.
Endoscopy_UCTN_Code_CCL_1AC_2AF

Competing interests: None

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Endoscopy 2011; 43: E115–E116
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

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