

Uncommon Presentation of Gastric Heterotopia Manifesting as a Polypoid Mass

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Keywords

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Heterotopia gástrica com apresentação polipoide rara

Palavras Chave

Heterotopia gástrica · Pólipo gástrico · Endoscopia

Introduction

Gastric heterotopia (GH) is characterized by the presence of differentiated gastric mucosa tissue outside the stomach, known as inlet patch, most commonly located in the proximal esophagus [1, 2]. The incidence ranges between 0.1 and 10% in adults [2]. Most patients with GH are asymptomatic; however, symptoms such as globus sensation, dysphagia, and odynophagia are associated due to acid secretion from the gastric mucosa [2, 3]. Complications including esophageal strictures have been reported, but polyps are rarely seen [4]. Despite the generally low incidence of relevant manifestations reported in the literature, controversies remain regarding the clinical significance of this condition.

Clinical Case

A 53-year-old man was referred for management of a sessile polyp (Paris 0-Is) in the proximal esophagus, identified during an esophagogastroduodenoscopy performed due to heartburn and regurgitation. Biopsies were compatible with a hyperplastic polyp.

The patient's medical history includes heavy tobacco consumption. Additionally, he was taking esomeprazole at a dose of 40 mg.

We repeated upper gastrointestinal endoscopy and observed two areas of pink mucosa oppositely positioned in the proximal esophagus (18 cm from the incisors), suggesting GH. One of these areas had a polypoid morphology with congestive, friable, and erosive mucosa measuring approximately 12 mm (Fig. 1). Narrow-band imaging evaluation showed a preserved glandular, vascular pattern (Fig. 2). Biopsies were taken from the lesion and anatomopathological assessment revealed fragments of gastric-type mucosa, consisting of occasional poorly oriented foveolar structures compatible with ulcerated GH. There was no metaplasia or dysplasia. No *H. pylori*-like microorganisms were observed in GH (Fig. 3). A multidisciplinary approach led us to decide on an expectant strategy due to its probable benign course. A follow-up endoscopy was performed,

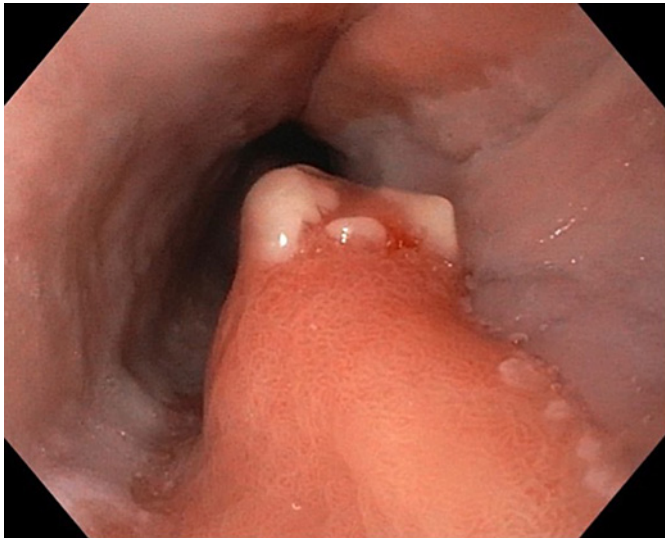


Fig. 1. Congestive and friable polyp arising from esophageal inlet patch in the proximal esophagus, in contralateral position to another inlet patch.

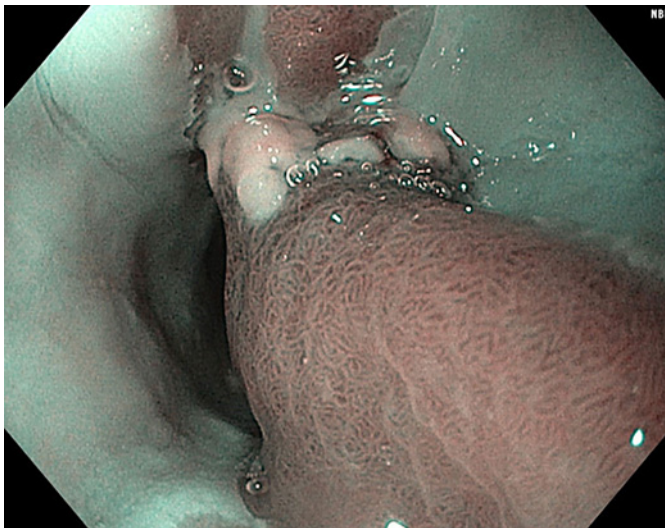


Fig. 2. Narrow-band imaging assessment of the polyp showing a preserved glandular and vascular pattern.

and the polyp showed no significant changes from the prior examination.

A diagnosis of GH with a polypoid morphology was made, which is compatible with a hyperplastic polyp. Hyperplastic polyps rarely originate from esophageal inlet patches and their potential carcinogenic pathway has not been fully documented. To our

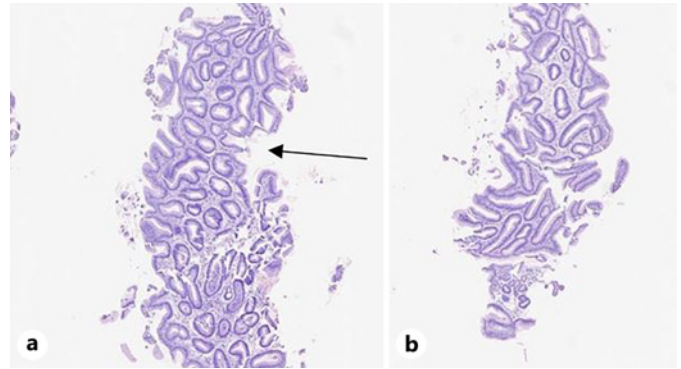


Fig. 3. Proximal esophagus: two distinct fragments (**a, b**) of gastric-type mucosa with foveolar structures (black arrow). Hematoxylin-eosin staining. ob2x.

knowledge, only a few case reports of GH with polypoid morphology exist in the literature [2, 4]. Further research is needed to determine the most appropriate management of these patients.

Statement of Ethics

Ethical approval was not required to this type of manuscript due to local laws. The patient has given written informed consent for publication (including the publication of images).

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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Author Contributions

Maria Inês Viegas, Daniel Brito, and Miguel Areia were involved in the endoscopic procedure and manuscript drafting. Luís Elvas, Sandra Saraiva, and Susana Alves were involved in manuscript drafting and critical revision. Ana Teresa Cadime reviewed the manuscript and gave final approval. All authors approved the final version.

Data Availability Statement

All data generated or analyzed during this study are included in this article. Further inquiries can be directed to the corresponding author.

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