

LARGE GASTRIC ADENOMATOUS POLYP: A CASE REPORT

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Abstract

Significance: Gastric polyps are most commonly incidental findings on upper GI endoscopy, small, and asymptomatic. We report a case of a large gastric tubulovillous adenoma measuring 5 cm, in a patient presenting with anemia, requiring transfusion. Endoscopic removal of the polyp was performed successfully.

Clinical Presentation: A 48 year old female was treated as a case of functional dyspepsia 2 years prior with resolution of symptoms. She was asymptomatic, until 2 months before consult, when she noted easy fatigability and dizziness. She denied melena and hematochezia. Workups revealed anemia and 3 units of packed RBC were transfused. FOBT was positive and an upper GI endoscopy revealed a gastric polyp, hence referral to our institution.

Management: Upper GI endoscopy showed a large, pedunculated gastric polyp measuring approximately 5 x 3 cm at the distal body. Biopsy of the polyp was signed out as consistent with a hyperplastic polyp. A second upper GI endoscopy was scheduled for polyp removal. 4cc of 1:10,000 dilution of epinephrine was injected at the polyp base, followed by snare polypectomy. There was bleeding post-procedure; 18 cc of 1:10,000 dilution of epinephrine was injected and 3 hemoclips deployed at the ulcer base, and bleeding resolved. The polyp measured 5.0 x 2.5 x 3.3 cm and histopathology revealed it to be a tubulovillous adenoma. Repeat upper GI endoscopy was advised after one year.

Recommendation: It is rare that we encounter polyps this large in the stomach. Guidelines recommend removal of such large polyps and surveillance.

Keywords: case report, polyp, adenoma, large, stomach

Introduction

The widespread use of endoscopy has resulted in increased detection of gastric mucosal lesions, many of which are found incidentally. Depending on histologic type, some gastric polyps have malignant potential and are precursors of early gastric cancer.¹ We present the case of a large (5cm) gastric tubulovillous adenoma causing transfusion-requiring anemia in a 48 year old female patient.

Case

A 48 year old female initially presented with a 2 year history of intermittent burning epigastric pain, relieved by food intake, and bloatedness. She was initially treated as a case of functional dyspepsia and prescribed omeprazole and domperidone for two weeks. Her symptoms resolved and no consult was done thereafter, until 2 months prior when she noted easy fatigability and dizziness. She denied melena and hematochezia. Her hemoglobin was 71 g/L, and a guiac-based fecal occult blood test was positive. Transfusion of 3 units packed RBC was done. She was advised an upper GI endoscopy and colonoscopy, but the colonoscopy was deferred due to poor bowel preparation. Her upper GI endoscopy revealed a gastric polyp and she was referred to our institution for polypectomy. On upper GI endoscopy, there was note of blood on insertion of the scope into the stomach. The gastric mucosa appeared nodular and coarse. There was a large, pedunculated gastric polyp measuring approximately 5 x 3 cm, noted at the distal body. Multiple biopsies of the polyp, body and antrum were taken for histopathologic analysis. The biopsy of the polyp was signed out as consistent with a hyperplastic polyp. Biopsies of the body revealed moderate active inflammation with increased eosinophilic infiltrates while biopsies of the antrum revealed mild chronic active inflammation with increased eosinophilic infiltrates; it was also positive for intestinal metaplasia. Both biopsies of the antrum and body were negative for dysplasia. A second upper GI endoscopy was scheduled for polyp removal. Pre-procedure complete blood count revealed a hemoglobin of 107 g/L, hematocrit of .34, mean cell hemoglobin concentration of 31.7 g/dL, and platelet count of $386 \times 10^9/L$. Prothrombin time, partial thromboplastin time, clotting time, and bleeding time were normal. We injected 4cc of 1:10,000 dilution of epinephrine at the polyp base and this was followed by snare polypectomy. There was bleeding post-procedure, and we injected 18 cc of 1:10,000 dilution of epinephrine and deployed 3 hemoclips at the ulcer base; the bleeding resolved. The polyp measured 5.0 x 2.5 x 3.3 cm and histopathology revealed it to be a tubulovillous adenoma with no malignant component in any part; the polyp base was negative for dysplasia. She was discharged well thereafter and advised to complete 8 weeks of oral lansoprazole and start iron

supplementation. Stool antigen test for *Helicobacter pylori* done as outpatient was negative. She underwent colonoscopy as an outpatient which revealed a minute, sessile polyp in the cecum, signed out as a tubular adenoma. Presently, the patient is well, asymptomatic and freely consumes a normal diet. She was advised to undergo a repeat upper GI endoscopy after one year.

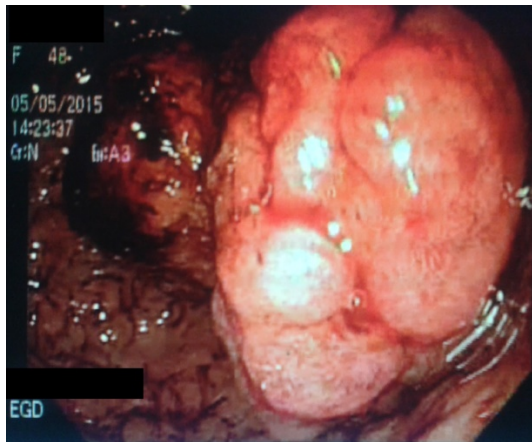


Figure 1: Upper GI endoscopy revealed a large pedunculated polyp in the distal body



Figure 2: Polyp base post polypectomy and post hemoclipping

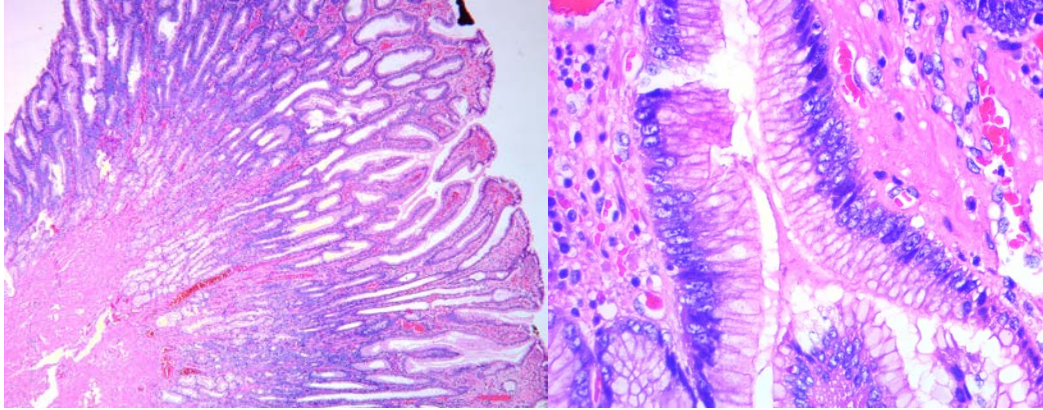


Figure 3: Microscopic examination of the polyp revealing tubular gastric glands and papillary structures lined by stratified columnar cells showing mild to moderate nuclear hypochromaticity and atypia

Discussion

Most gastric polyps are incidentally discovered in about 2% of upper endoscopies, most performed for unrelated lesions. Occasionally, they become inflamed and eroded, and bleeding is unusual.² Gastric adenomas are defined by the World Health Organization as circumscribed, polypoid lesions composed of either tubular and/or villous structures lined by dysplastic epithelium.² They are the most common gastric neoplastic polyp and constitute <1% of all gastric polyps in the Western world, but may constitute up to a quarter of all gastric polyps in some East Asian nations where incidence of gastric cancer is high.³ They frequently arise in the background of atrophy and intestinal metaplasia, and are most common in the sixth and seventh decades of life.³ In a study by Gencosmanoglu, et. al., analysis of 150 endoscopic polypectomy specimens showed 40.7% of polyps were located in the antrum, with adenomas comprising 2.7% and polyps 2-3 cm in size comprising only 1.2% of the lesions.⁴ Our patient was younger at 48 years old, with a large adenoma measuring 5 cm at the distal body. A case report from India by Sharmila, D., et.al., also reported a case of a large adenoma measuring 9 cm in the body of the stomach removed surgically.⁶ To our knowledge, this is the only case report of a large gastric adenoma in the Philippines.

The larger the adenoma, the greater the probability it contains a foci of adenocarcinoma. Adenocarcinoma arising from adenoma is reported in 9%-20%.⁴ Complete removal of the adenoma is recommended and should be performed when safe to do so. An examination of the whole stomach should be made for mucosal abnormalities, and any abnormalities biopsied.¹ In our patient, the polyp was negative for malignancy on histopathologic analysis; the polyp base was also negative for dysplasia. Biopsies

of the other areas of our patient's stomach were likewise negative for dysplasia. As recommended by the American Society of Gastrointestinal Endoscopy (ASGE) guidelines⁷, our patient was advised repeat upper GI endoscopy after one year.

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