

## Images in...

## Gastrointestinal bleeding caused by gastritis cystica polyposa

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## DESCRIPTION

A man in his 50s presented with a 2-day history of melaena. He had undergone a Billroth II (B-II) gastrectomy for a benign duodenal ulcer 32 years ago. He had a history of heavy alcohol intake and smoked 20 cigarettes per day. Laboratory testing revealed anaemia. Oesophagogastroduodenoscopy revealed a small amount of blood in the gastric remnant and a polypoid lesion at the B-II gastroenterostomy site. Bleeding at the polypoid lesion could be seen on contact with the endoscope. However, no treatment was needed during the oesophagogastroduodenoscopy because of spontaneous haemostasis. A biopsy specimen from the lesion demonstrated foveolar epithelial hyperplasia and marked cystic dilatation of pyloric glands (figure 1). The patient was transfused with four units of packed red blood cells. He ceased alcohol intake and cigarette smoking and did well without further blood transfusion. No bleeding was seen at 46 days (figure 2) after the initial oesophagogastroduodenoscopy and endoscopic ultrasonography revealed multiple cystic lesions mainly in a thickened submucosal layer. Based on these results, the patient was diagnosed with gastrointestinal bleeding caused by gastritis cystica polyposa (GCP). GCP is usually

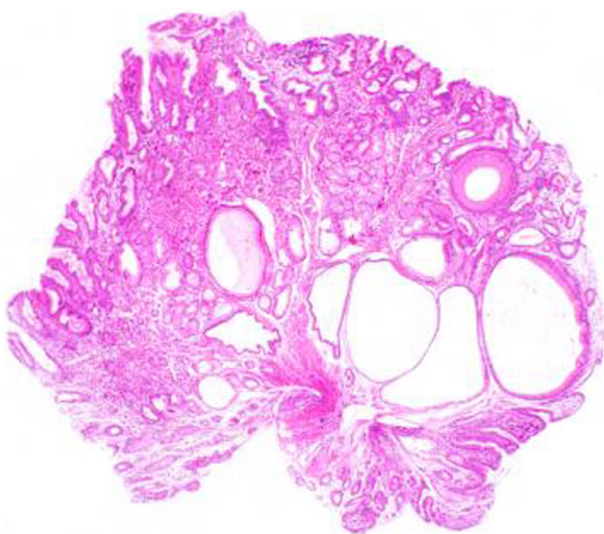
observed more than 10 years after B-II gastrectomy.<sup>1</sup> The disease is characterised by gastrointestinal bleeding and coexistence with gastric remnant carcinoma. In cases with massive bleeding and/or suspicion of malignancy, endoscopic haemostasis or surgery are the treatments of choice. GCP is considered to be a precancerous lesion, therefore follow-up of patients with GCP is essential to detect gastric remnant carcinoma including gastric carcinoma arising at the site of GCP.<sup>2 3</sup>

Competing interests None.

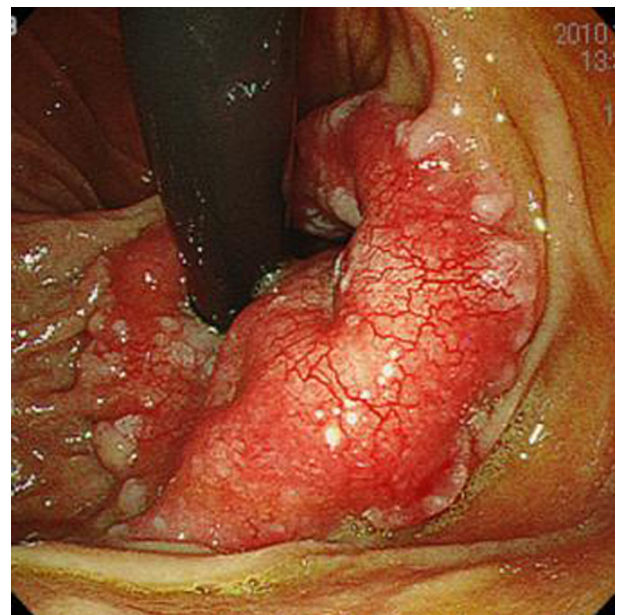
Patient consent Obtained.

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**Figure 1** A biopsy specimen from the lesion demonstrates elongated, tortuous foveolae and hyperplastic and cystically dilated underlying pyloric glands. The lamina propria is slightly oedematous and contains a mild chronic inflammatory cellular infiltrate (H&E, original magnification x20).



**Figure 2** Endoscopic retroflex view of the Billroth II gastroenterostomy site at 46 days after the initial oesophagogastroduodenoscopy. A polypoid lesion (ie, gastritis cystica polyposa) can be seen with no bleeding.

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Tominaga K, Nimura S, Takahashi K, Maetani I. Gastrointestinal bleeding caused by gastritis cystica polyposa. *BMJ Case Reports* 2011; 10.1136/bcr.08.2011.4617, Published XXX

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