The Unknown Origin Of Gastritis Cystica Profunda

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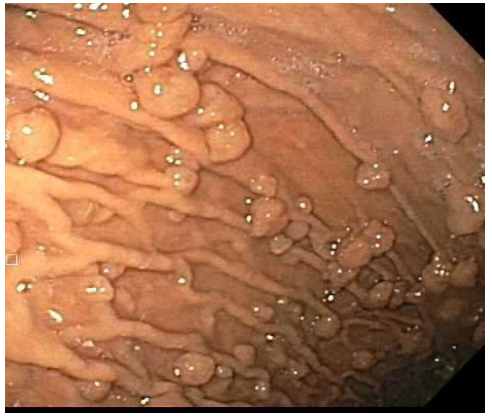
Introduction

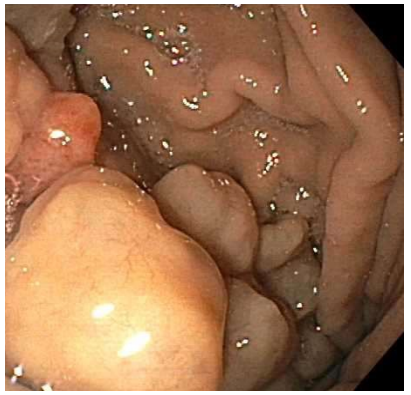
- Gastritis Cystica Profunda was first described in literature by Scott and Payne in 1947. It has been defined as a submucosal benign lesion associated with cystic gland growth.
- Given its rarity, the research on this topic remains quite limited.
- Gastritis Cystica Profunda (GCP) is most often an incidental diagnosis however symptoms can range from GI bleeding and abdominal pain, to symptoms of weight loss and gastric outlet obstruction.

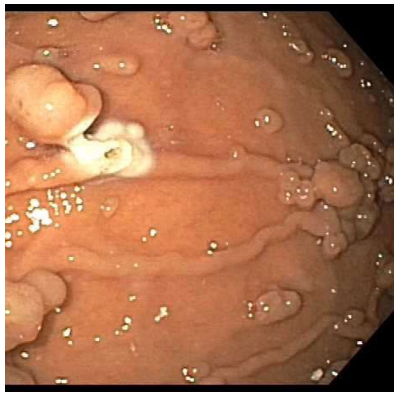
Case Presentation

- A 72-year-old female with a PMH of HTN, DM, breast cancer (post resection in 2012), GERD presented with a hemoglobin of 4 in the absence of overt GI bleed.
- The patient had no prior history of Gastric surgeries however had an upper GI endoscopy a year prior. Multiple gastric polyps were visualized. Biopsy was significant for reactive gastropathy, and negative for H pylori, metaplasia, and dysplasia. Patient was lost to follow up post endoscopy.
- During this admission, CT Angio was negative for acute bleed. An upper endoscopy revealed innumerable fundus gland polyps which were removed. Histopathology of the polyps was consistent with early GCP.
- Hgb levels improved on IV iron. Blood was not administered during hospitalization as our patient was a Jehovah's Witness.
- At this time, additional modalities such as video capsule endoscopy are being performed to further investigate occult bleed origin.

Endoscopy Images







Figures 1,2,3: Multiple sessile and pedunculated polyps visualized in the gastric body

Endoscopy Findings

- Multiple (>100) medium and large gastric polyps. Seven of the large polyps were resected and retrieved.
- One moderate size, erythematous gastric polyp. Resected and retrieved.
- Histopathology findings were consistent with early Gastritis Cystica Profunda.

Discussion

- Mucosal injury from gastric surgeries has been hypothesized as a trigger for GCP. Our case, however, demonstrated an occurrence of GCP without a prior history of GI surgery. This raises the question of whether chronic untreated GERD in our patient led to significant intrinsic mucosal injury triggering reactive gastropathy as seen on prior endoscopy and subsequent GCP formation.
- GCP has mainly been managed with mucosal resection per prior reports. In the case of the presence of multiple polyps such as ours, there is no definitive treatment approach recommended.
- Multiple case studies have associated GCP with the development of adenocarcinoma. The timeline between GCP and development of carcinoma remains a mystery and hence there is limited data on surveillance guidelines and recurrent rates for these lesions.

References

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