Heterotopic gastric mucosa mimicking a rectal submucosal tumor

Fig. 1 Endoscopic view in a man with a 4-year history of intermittent tenesmus showing a protrusive lesion in the rectum.

Fig. 2 Endoscopic ultrasound (EUS) image showing that the tumor was originating from the submucosal layer.

A 61-year-old man came to our hospital with a 4-year history of intermittent tenesmus. There was no family history of rectal carcinoma. Upon presentation, his physical examination was remarkable only for a soft mass on the posterior wall of the rectum. Laboratory studies showed a positive fecal occult blood test but no other test abnormalities. Colonoscopy revealed a protrusive lesion, 10 mm in diameter, located about 5 cm away from the anal verge (● Fig. 1). Endoscopic ultrasound (EUS) showed that the mass was originating from the submucosal layer (● Fig. 2).

The patient underwent endoscopic submucosal dissection (ESD) (● Fig. 3) and histopathologic examination revealed heterotopic fundic-type gastric mucosa within the submucosal layer (● Fig. 4). *Helicobacter pylori* was not detected in the dissected specimen. He was discharged 5 days after ESD and remained well after a 9-month follow-up.

Heterotopic gastric mucosa may occur anywhere in the gastrointestinal tract and uncommonly involves the rectum [1]. When the tissue is found in the rectum, it is usually on the posterolateral wall between 5 cm and 8 cm from the anal verge. The most common presenting symptoms are painless rectal bleeding, tenesmus, rectal or perineal ulceration, and anal or abdominal pain, but it may also be found incidentally during colonoscopy [2, 3]. Most of these lesions are found

within the mucosal layer, and the endoscopic appearance may be of a polyp, diverticulum, ulcer, or mucosal changes such as flaps, plaques, or folds. Definitive diagnosis is made on the basis of histologic examination, and the most common histologic type is fundic mucosa.

Intervention is recommended when symptoms are present. Current treatment modalities include medical therapy (H_2 blockers, proton pump inhibitors), endoscopic therapy (snare polypectomy, ablation, etc.), and surgical excision. In the present case, the lesion originated from the submucosal layer and was successfully managed with ESD. Long-term follow-up is recommended to check for recurrence and for gastric cancer screening.

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Competing interests: None

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Fig. 3 Endoscopic submucosal dissection (ESD) showing: **a** the endoscopic appearance during the procedure; **b** the wound surface after ESD; **c** the resected specimen.

Fig. 4 Histologic appearance of the resected specimen showing heterotopic gastric mucosa.

Bibliography

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