A 44-year-old man was referred due to chronic dysphagia to solids and a persistent globus sensation. Esophagogastroduodenoscopy (EGD) revealed a nodular inlet patch with a hyperplastic polypoid appearance occupying 70% of the luminal circumference in the proximal esophagus from 18 to 20 cm. Narrow-band imaging did not reveal dysplastic features and biopsies confirmed gastric heterotopia without dysplasia. Further work-up with barium swallow, chest X-ray, esophageal manometry, and pH testing were normal. Medical therapy with twice-daily proton pump inhibitor did not improve his symptoms. As such, endoscopic resection was proposed.

The procedure was performed under general anesthesia with endotracheal intubation (Video 1). Piecemeal endoscopic mucosal resection (EMR) was performed using a Duette multiband mucosectomy device (Cook Medical, Limerick, Ireland) after submucosal lifting using normal saline with diluted methylene blue. The entire inlet patch was successfully removed using nine bands with minor bleeding controlled using hemostatic forceps. Diluted triamcinolone (34 mg) was injected into the EMR defect for stricture prophylaxis, followed by treatment with budesonide slurry and sucralfate suspension for 4 weeks. The pathology revealed gastric oxyntic mucosa with low grade dysplasia. Follow-up EGD at 1 year confirmed the absence of any residual inlet patch and no dysplastic findings. Crucially, the patient had complete resolution of his chronic symptoms.

by most endoscopists due to small size, but the finding of low grade dysplasia in our case highlights the importance of close examination and consideration for endoscopic intervention when there are abnormal features. Small, symptomatic inlet patches can be treated by EMR or mucosal ablation [3, 4], whereas larger or polypoid inlet patches may be completely and safely removed by multiband mucosectomy, as demonstrated by our case.

Conflict of Interest

The authors declare that they have no conflict of interest.

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References