A 42-year-old woman with early-stage cancer of the esophagogastric junction was admitted to our hospital for treatment. Ambulatory endoscopic examination revealed a round, elevated lesion, 6 × 5 mm in size, with a reddish surface on top of a 2-cm polyp (Fig. 1) and evidence of gastroesophageal reflex disease (GERD). Magnifying endoscopy showed that the lesion mostly had an amorphous pit pattern with irregularly arranged microvessels in the central area. Histological examination of a biopsy specimen confirmed the presence of an inflammatory esophagogastric polyp with concurrent adenocarcinoma. The patient was prescribed a proton-pump inhibitor (PPI; lansoprazole 30 mg/day) and an endoscopic examination after 1 month revealed that the polyp had completely disappeared and the residual lesion was stage 0–IIa + IIc (Fig. 2a).

Histological examination of the resected specimen showed a well-differentiated adenocarcinoma in situ without vascular invasion (Fig. 2c); complete resection of lateral and vertical margins was confirmed.

Endoscopically, a short segment of Barrett esophagus was noted in the surrounding mucosa, but it was not clear whether there was any relation between the Barrett epithelium and the carcinoma. There was no recurrence or evidence of metastasis during a follow-up period of 5 years.
An inflammatory esophagogastric polyp is characterized endoscopically as a hyperplastic or/squamous polyp arising at the esophagogastric junction and histologically as foveolar or/squamous epithelium with inflammatory changes [1,2]. It is thought that this lesion is closely associated with inflammation of the esophagogastric junction, such as GERD in the present case, and it is treated effectively with a PPI. Here, we describe for the first time a rare case of adenocarcinoma occurring concurrently with an inflammatory esophagogastric polyp, which completely disappeared after administration of a PPI. Cases with only adenocarcinoma showing inflammatory esophagogastric polyp-like appearance and cases of inflammatory polyp with bizarre stromal cells, “pseudomalignant erosion”, at the esophagogastric junction have been reported previously [2–5], but simultaneous occurrence of adenocarcinoma on an inflammatory esophagogastric polyp has not been reported. In such cases, it is thought that administration of a PPI aids confirmation of diagnosis of esophagogastric junctional carcinoma and that magnifying endoscopy is useful for demarcating the lesion prior to endoscopic resection.

References
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