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 reflux 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 – Ila + IIC (Fig. 2a).

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 esophago-gastric polyplike 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
3 Nino-Murcia M, Friedland GW. A characteristic “Inflammatory polyp” at the esophagogastric junction that was a cancer. Am J Roentgenol 1988; 150: 948–949

Bibliography
Endoscopy 2010; 42: E176–E177
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author
T. Yoshida, MD
Department of Gastroenterology
Hokkaido University Graduate School of Medicine
Division of Endoscopy
Hokkaido University Hospital
Nishi-7, Kita-15
Kita-ku, Sapporo
Hokkaido 060-8638
Japan
Fax: +81-11-7067867
peugeot307ccs16@yahoo.co.jp