Collagenous gastritis

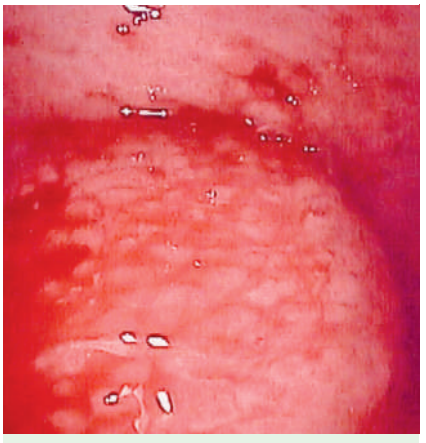

Fig. 1 Appearance of the gastric antrum.

A 19-year-old woman reported frequent postprandial vomiting since age 4, intermittent diarrhea since age 15, failure to thrive (body mass index 15.2) and puberty retardation (menarche 17 years). Her parents were first cousins. At age 15, iron-deficiency anemia (hemoglobin 8.4 g/dL, ferritinemia 3 ng/ml) and nodular gastritis with *Helicobacter pylori* had been diagnosed. Duodenal biopsies showed normal findings. She received successful *H. pylori* eradication treatment, with a long course of proton-pump inhibitors and iron supplementation, but the chronic vomiting and diarrhea were unchanged. At age 16, the gastric nodular pattern was still present, and *H. pylori* was absent. She was referred to our centre in April 2006 (aged 19).

A diffuse gastric nodular pattern with easy bleeding on contact was observed on upper digestive endoscopy (**Fig. 1**). Subepithelial collagenous deposits were found in all the gastric specimens. The collagenous band was irregular, discontinuous and measured up to 100 µm, with some extensions into the lamina propria. Entrapped dilated capillaries, mild nonspecific inflammatory infiltrates, and partial epithelial detachment at the edge of some subepithelial deposits were observed (**Fig. 2** and **3**). Hemoglobin and ferritinemia determinations, jejunoscopy, ileocolonoscopy (including biopsy specimens) and entero-CT showed normal findings. We concluded that the diagnosis was collagenous gastritis.

Collagenous gastritis is a rare condition (22 cases to date) of unknown etiology, assumed to be a counterpart of collagenous colitis [1,2]. Younger patients usually present with chronic vomiting and iron-deficiency anemia, and there is no extragastric involvement [3]. Adults often complain of chronic diarrhea sometimes associated with collagenous [4] (or rarely, lymphocytic [3]) colitis. Treatments with aminosalicylates, corticosteroids, and azathioprine have been occasionally proposed with no results that have been evaluated [5]. In our patient, prednisone 50 mg/d for 4 weeks with subsequent tapering and cessation led to rapid clinical remission which has still been sustained after 10 months.

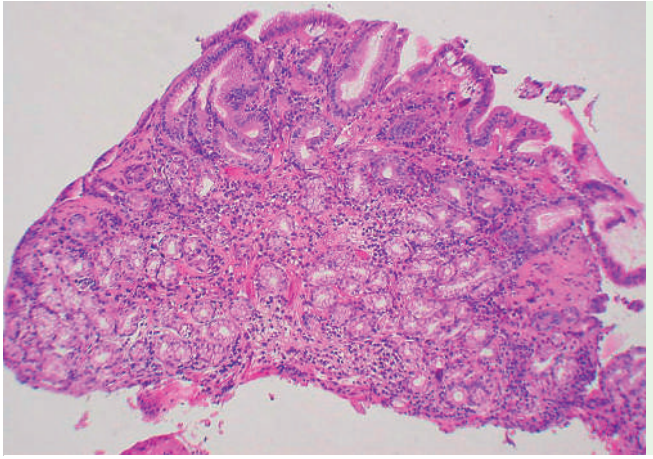

Fig. 2 Histopathological section of the antrum (hematein–eosin–safran staining).

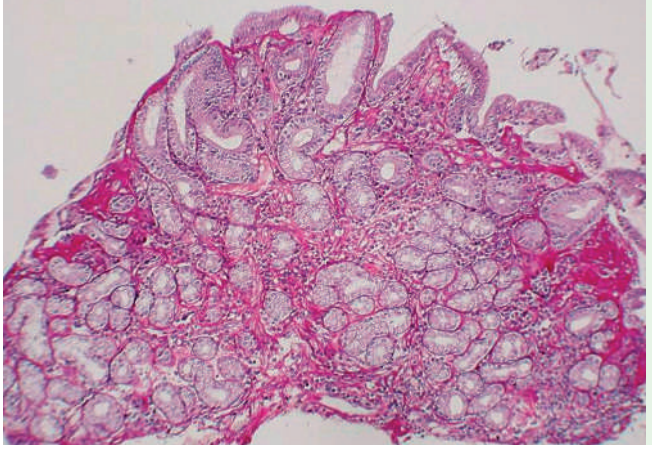

Fig. 3 Histopathological section of the antrum (Sirius red staining).

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Bibliography
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