An Unexpected Transformation

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Abstract

In this study, a middle aged woman, diagnosed with decompensated cirrhosis presented with complaints of malaise and exertional dyspnea since 3 months, with history of repeated blood transfusions. On evaluation, she was pale and icetric with grade II ascites. Further work up was revealed severe iron deficiency anemia. An upper digestive tract endoscopy (UGIE) revealed presence of small low risk esophageal varices and actively oozing gastric antral vascular ectasia.

Keywords: GAVE, portal hypertension, APC, cirrhosis, upper GI bleed

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Short Report

A middle aged woman, diagnosed with decompensated cirrhosis presented with complaints of malaise and exertional dyspnea since 3 months, with history of repeated blood transfusions. On evaluation, she was pale and icetric with grade II ascites. Further work up was revealed severe iron deficiency anemia. An upper digestive tract endoscopy (UGIE) revealed presence of small low risk esophageal varices and actively oozing gastric antral vascular ectasia (GAVE, PANEL A, first described by Rider in 1953) [1]. Repeated sessions of Argon plasma coagulation (APC, PANEL B) was offered every 2-3 weeks for 4 months. Further follow up endoscopy was showed diffuse nodular transformation of GAVE without active ooze (PANEL C). Further APC sessions were not done and the patient did well on iron supplementation. Eight months after initial APC, an UGIE showed presence of extreme nodular antral gastropathy (NAG), a rare variant of GAVE, obliterating the antral region (PANEL D). Biopsies from the lesions revealed presence of hyoerplastic foveolae with focal ulcerations with dense mixed inflammation in the absence of Helicobacter pylori. NAG (first described by Takemoto et al in 1962) [2] is a type of GAVE seen in young women with long standing antral gastritis and also in persons with chronic proton pump inhibitor use, associated with hypergastrinemia with reduced gastric pH (a pathological condition seen with cirrhosis also) [3]. It has been shown in few case reports that use of octreotide ameliorates NAG even though this treatment modality needs validation [4]. Polypoidal transformation of GAVE has been previously reported to occur as a complication of APC. The complications of APC reported in literature include gastric perforations, antral strictures, development of hyperplastic polyps and multifocal neoplasia of the stomach [5]. Our patient is currently doing well on iron supplementation therapy without symptoms and is on surveillance endoscopy on follow up.

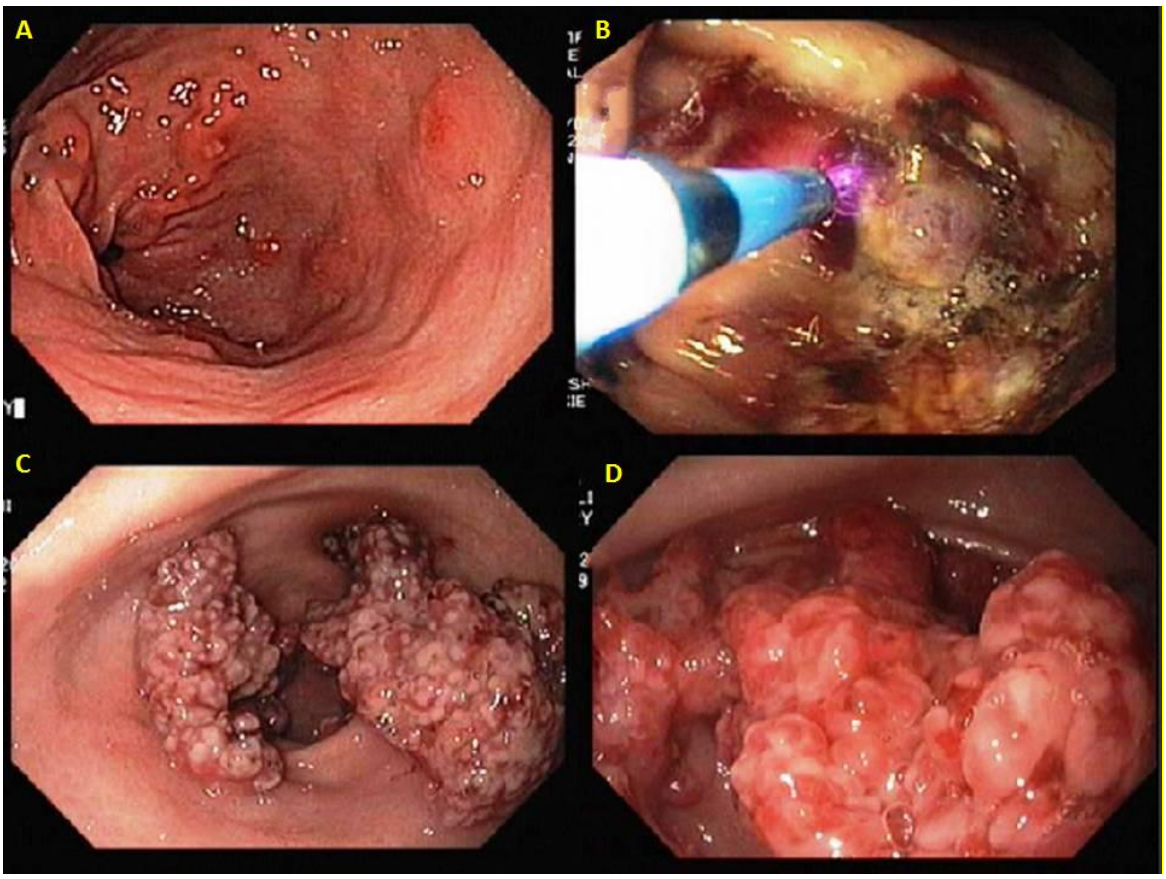

Figure. Endoscopic images of upper gastrointestinal tractus

References

1. Rider JA, Klotz AP, Kirshner JB. Gastritis with veno-capillary ectasia as a source of massive gastric hemorrhage. Gastroenterology. 1953;24(1):118-23.
2. Takemoto M, Mizuno Y. Endoscopic diagnosis and gastric biopsy in chronic gastritis. Gastroenterol Endosc. 1962;4:310-9.
3. Samloff, I. M. Multiple gastric red spots, capillary ectasia, hypergastrinemia and hypopepsinogenemia i in cirrhosis: A new syndrome? Hepatology. 1988;8(3):699-700.
4. Alan Brijbassie, Abdullah Al Osaimi, Steven M Powell. Hormonal Effects on Nodular GAVE. Gastroenterology Research. 2013;6(2):77-80
5. Izquierdo S, Rey E, Gutiérrez Del Olmo A, Almansa C, Andrés Ramírez Armengol J, Díaz-Rubio M. Polyp as a complication of argon plasma coagulation in watermelon stomach. Endoscopy. 2005;37(9):921.