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Imraporn B
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Case 1

A 40 years old male developed upper GI bleeding with coffee ground contents. His underlying disease is symptomatic HIV infection with CD4 count = 170 cell/ml.

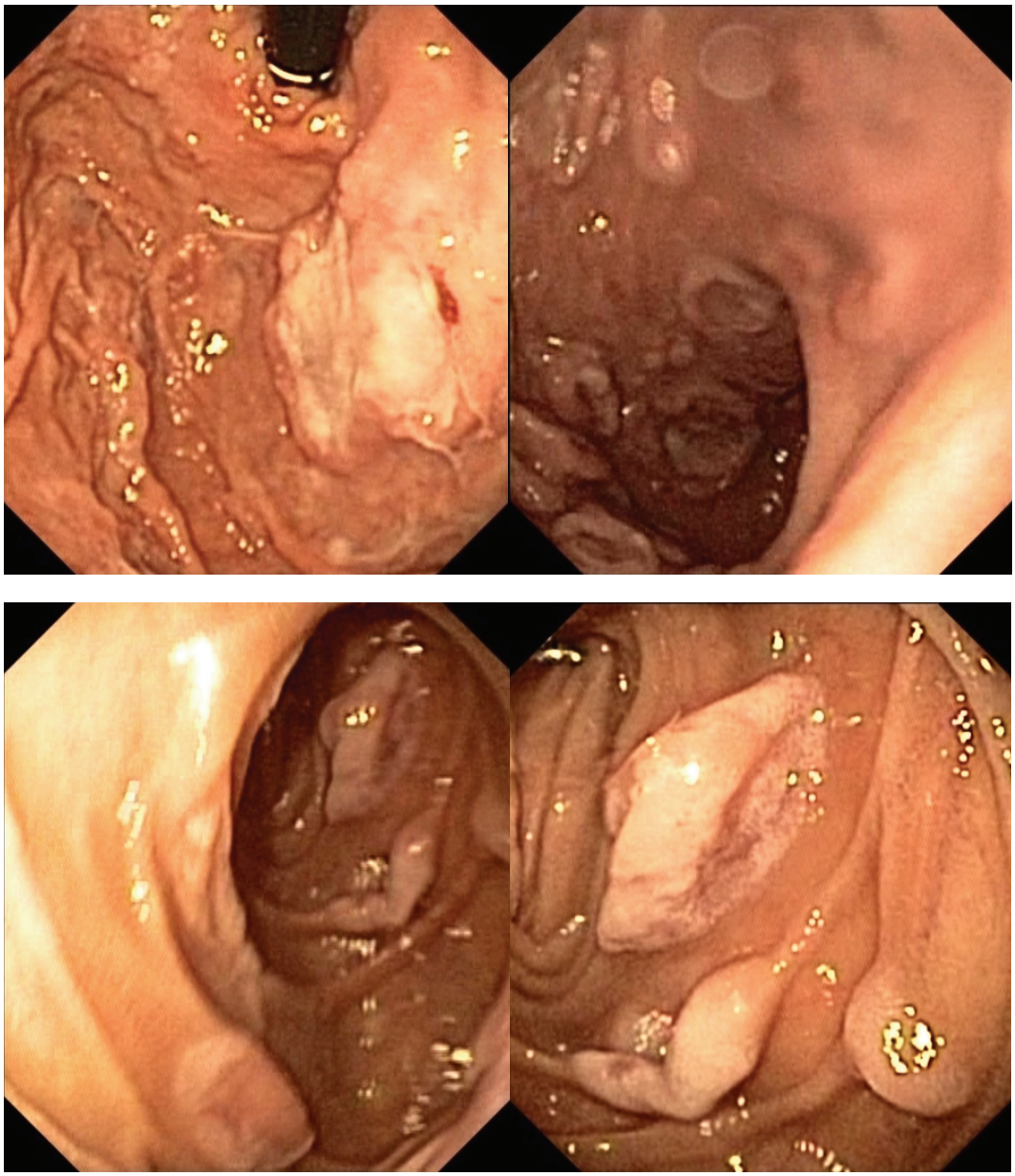

Figure 1

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In this case, pathology showed non Hodgkin lymphoma. He was referred to hematologist for chemotherapy.

Discussion/Comment:

Development of lymphoma is considered an AIDS-defining condition.[1] HIV associated NHL typically has an aggressive presentation with rapidly growing disease and prominent B symptoms.[2] The gastrointestinal tract is a common site including unusual sites such as anus and rectum. Prognosis is generally poor, with 2-year survival rates of 10-20%. However survival is improved with HAART regimen.

REFERENCE

1. 1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR Morb Mortal Wkly Rep 1992;41:1.
2. Kaplan LD. Clinical management of human immunodeficiency virus-associated non-Hodgkin's lymphoma. J Natl Cancer Inst Monogr 1998;23:101.

CASE 2

A 60 years old male, developed upper GI bleeding with coffee ground contents. He has no abdominal pain. His underlying disease is squamous cell lung cancer with brain metastasis.

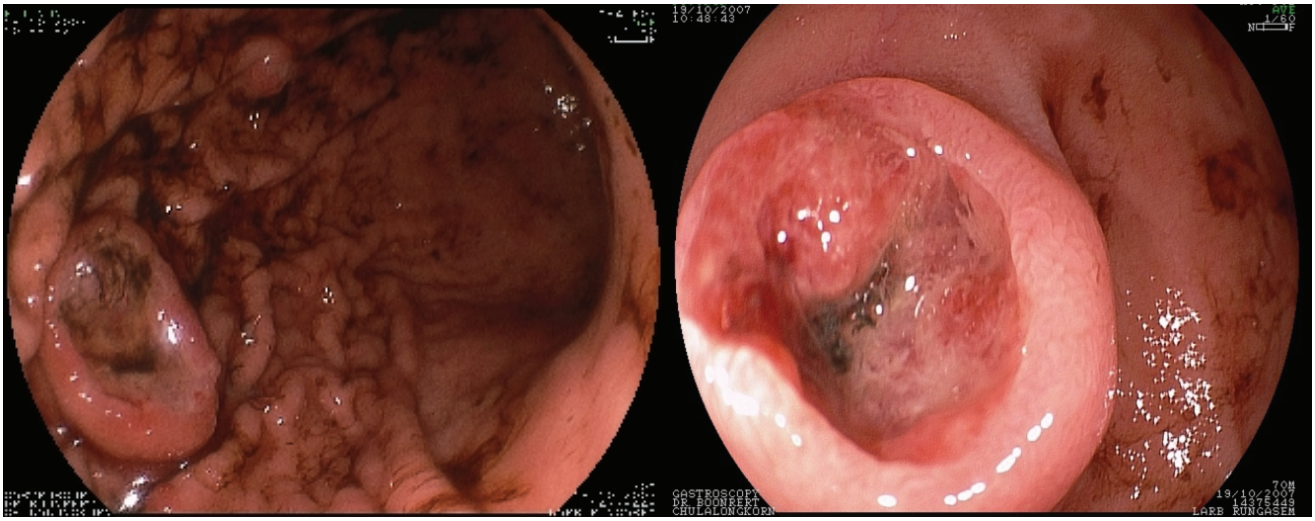

Figure 2

In this case, pathology revealed metastatic squamous cell cancer. He was treated with palliative chemotherapy. No recurrent bleeding occurred.

Discussion/Comment

Haematogenous metastases to the stomach are a rare event.

The most frequent tumors involved in secondary gastric sites are melanoma, breast, and lung cancer. Most patients with gastrointestinal metastases are asymptomatic.[1] Abdominal pain is the most frequent (80% of the cases) symptom in the symptomatic patient. Differential diagnosis are lymphoma, ectopic pancreas and carcinoid tumor. These lesions may present with three different appearances[3]: (1) multiple nodules of variable size with a central ulcer; (2) submucosal, raised, and ulcerated at the tip and defined as "volcano-like"; and (3) raised areas without a central ulcer. In these patients, the prognosis is very poor.

REFERENCE

1. Kadakia SC, Parker A, Canales L. Metastatic tumors to the upper gastrointestinal tract: endoscopic experience. Am J Gastroenterol 1992;87:1418-23.
2. Green LK. Hematogenous metastases to the stomach. A review of 67 cases. Cancer 1990;65:1596-600.

CASE 3

A 30 year-old man with known history of familial adenomatous polyposis came to the hospital for EGD. EGD finding was shown as pictures.

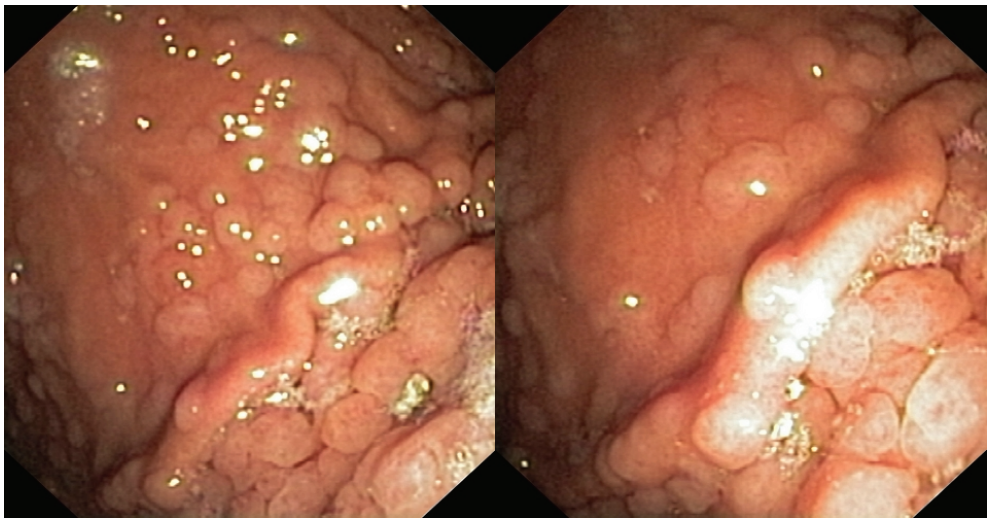

Figure 3

EGD findings revealed multiple small gastric polyps located in fundus.

His diagnosis is multiple fundic gland polyps.

Discussion

Fundic gland polyps (FGPs) are the most common gastric polyps in both familial adenomatous polyposis (FAP) and sporadic patients. FGPs are reported to occur in 12.5.

to 84% of patients with FAP whereas sporadic FGPs are identified in 0.8 to 1.9% of non-FAP patients undergoing upper gastrointestinal endoscopy. FAP associated FGPs tend to be more numerous, occur at a younger age, and have a more equal gender distribution. The pathogenesis of FGPs remains uncertain. FGPs have generally been regarded as non-neoplastic lesions. Neoplastic progression of FGPs in FAP patients has occasionally been reported, including the development of a large dysplastic gastric polyp or even infiltrating gastric cancer[1-4]. Despite the lack of more exact estimates of the risk of tumor progression in patients with FAP and fundic gland polyposis, molecular evidence indicates that FAP associated FGPs are neoplastic polyps. Similar to the presence of other neoplastic polyps of the upper gastrointestinal tract in patients with FAP, the presence of fundic gland polyposis may warrant close endoscopic surveillance[5].

REFERENCE

1. Zwick A, Munir M, Ryan CK, *et al*. Gastroenterology 1997; 113:659-63.
2. Odze RD, Quinn PS, Terrault NA, *et al*. Hum Pathol 1993; 24:442-8.
3. Coffey RJ, Knight CD, Van Heerden JA, *et al*. Gastroenterology 1985;88:1263-6.
4. Hofgartner WT, Thorp M, Ramus MW, *et al*. Am J Gastroenterol 1999;94:2275-81.
5. Abraham SC, Nobukawa B. AJP 2000;157:747-54.