

Digestive Endoscopic Corner

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Case 1

A 15 years old female, Burmese patient presented with diffuse erythematous palpable purpura of lower extremities for 3 days and developed blister in the next

2 days. Subsequently, she developed periumbilical pain and hematochezia. EGD and colonoscopy were done . Please, describe skin lesions (A-B) and endoscopic findings; EGD(C-D) and colonoscopy (E-F) ?.

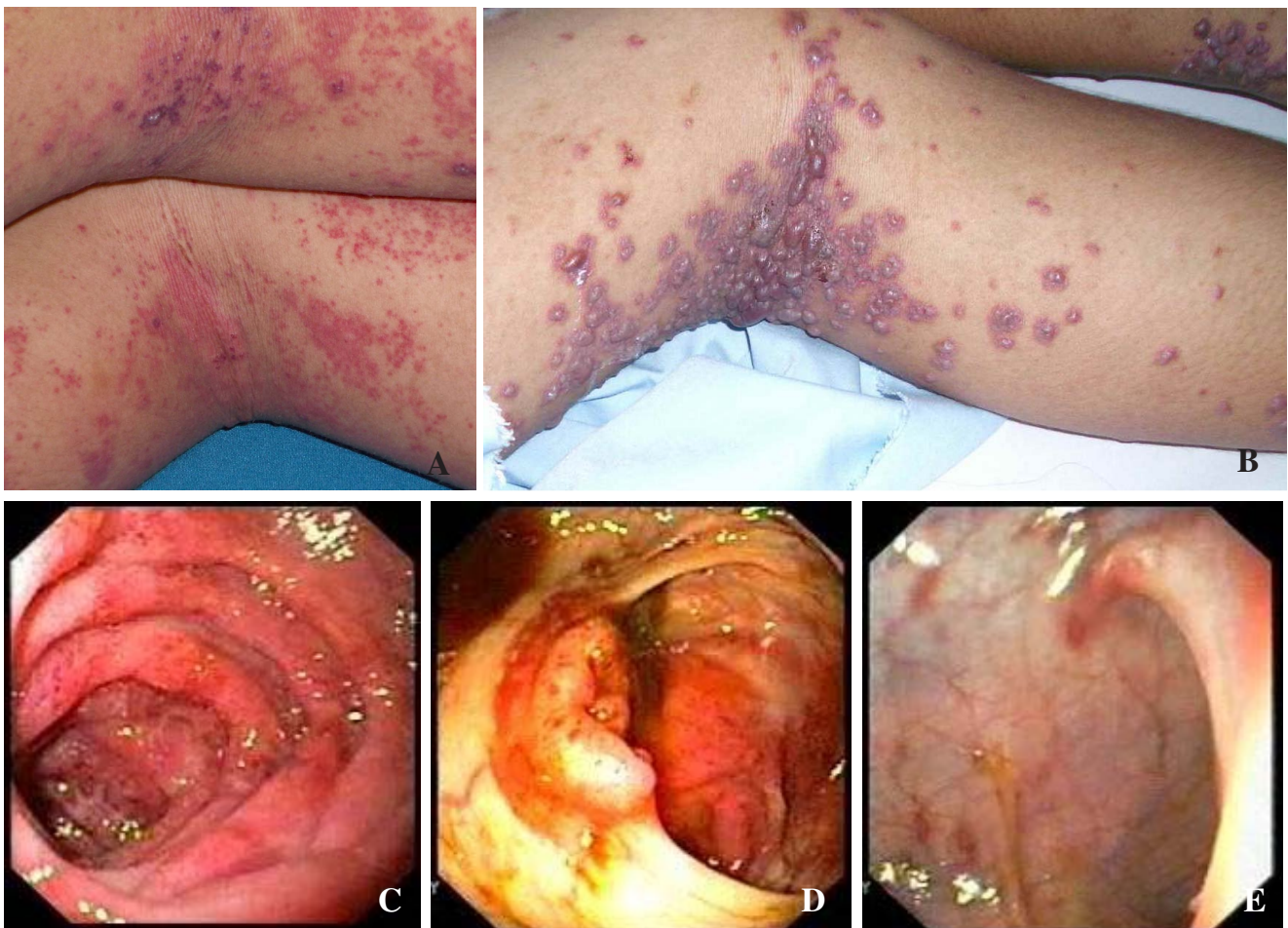


Figure 1

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The skin lesions showed numerous hemorrhagic vesicles on erythematous base mixed with purpuric macula of various sizes and shapes distributed on the bottoms, thighs and lower legs. Directed immunofluorescence studies of the skin specimen showed deposition of IgA, minimal IgM and C3 at blood vessel walls. This finding is consistent with Henoch-Schonlein Purpura. Colonoscopy showed multiple small scattered ring-like petichiae in the descending and ascending colon with diffuse mucosal redness. The ileo-cecal valve was redness, edematous with numerous small petichiae on top. Some area of the cecum showed diffuse mucosal redness with petichiae alternated with normal appearing mucosa. EGD showed normal appearing of esophagus and stomach but the duodenum showed diffuse mucosal redness, edema, small ring-like petichiae with multiple small ulcers and hemorrhagic erosion prominent at the second part of the duodenum. Duodenal biopsy showed moderate to

severe acute erosive and chronic duodenitis and colon biopsy showed moderate acute erosive colitis with increased lymphoplasmacytic and eosinophilic infiltrated and focal thickening of subepithelial area. There was no evidence of intestinal vasculitis.

Diagnosis: Henoch Schlein Purpur

In some case, the intestinal biopsy may not shown the leukocytoclastic vasculitis (LCV) pattern because the biopsy specimen must cover the submucosa layer, which was rich of blood vessels, especially post capillary venules, the affected part of gastrointestinal tract vasculitis. Gastrointestinal tract symptoms in Henoch-Schonlein Purpura usually resolve spontaneously but response to corticosteroid, immunosuppressive drugs. Plasma exchange have been reported anecdotally in severe disease. This patient was given prednisolone, the skin lesion and bowel symptoms were improved in a few days.

Case 2

A 50 years old female patient present with prolong history of heartburn. EGD was performed. Describe the lesion and give the diagnosis ?

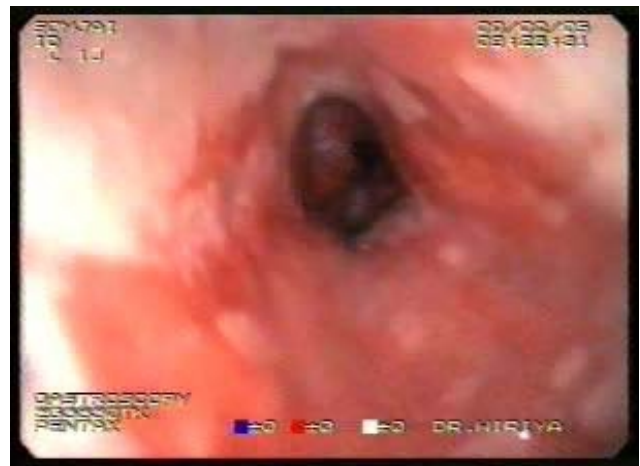


Figure 2

The gastroscopy showed the tongue of salmon-colored mucosa extending from proximal of gastroesophageal junction (GEJ) into the normal pale esophageal mucosa with intervening by the islands of squamous epithelium. This lesion was the characteristic of Barrett's esophagus.

Barrett's esophagus is the condition in which an abnormal, intestinal-type epithelium called specialized intestinal metaplasia replaces the stratified squamous

epithelium that normally lines the distal esophagus. The condition develops as a consequence of chronic gastroesophageal reflux disease (GERD), and predisposes to the development of adenocarcinoma of the esophagus. Endoscopist should label the site and length form incisor where the biopsy was performed because if biopsy at GEJ, the histopathology is resembled as Barrett's esophagus.

When the squamocolumnar and GEJ coincide

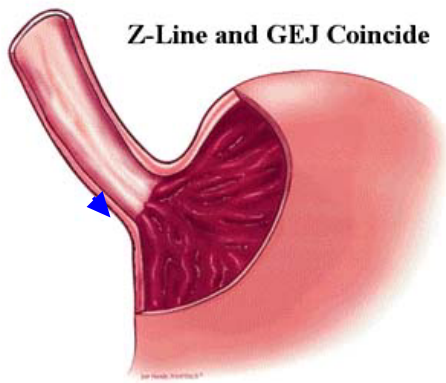


Figure 3

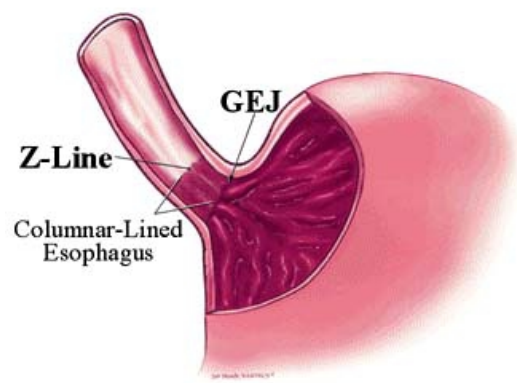


Figure 4

(showed in Figure 3), the entire esophagus is lined by squamous epithelium. When the squamocolumnar junction is located proximal to the GEJ (showed in Figure 4), there is a columnar-lined segment of esophagus. If biopsy specimens from that segment area, then the diagnosis of Barrett's esophagus is done. Long

segment Barrett's esophagus is described when the distance between the Z-line and the GEJ is more than >3 cm, and short-segment Barrett's esophagus defined by that distance is lesser than <3 cm. If the biopsy specimens from the Z-line showed intestinal metaplasia, this condition called intestinal metaplasia at the GEJ.

Case 3

A 60 years old male presented with iron deficiency anemia. EGD finding showed normal. Colonoscopy was performed. What is the diagnosis ?



Figure 5

The colonoscopy showed a large and bulky polypoid mass located at ascending colon and partially obstructed the lumen. The characteristic of this mass suggested the primary lesion of villous adenoma. The pathological study reveal a well-differentiated adeno-

carcinoma. Iron deficiency anemia is one of the important clinical manifestation of colon cancer especially the tumor that located on the right side colon. Obstruction is an uncommon symptoms of right side colon cancer due to the large diameters of the cecum.

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Case 4

A 65 years old male present with UGIB. He had the underlying disease of ischemic stroke with bed ridden status. EGD was performed. What is the diagnosis ?

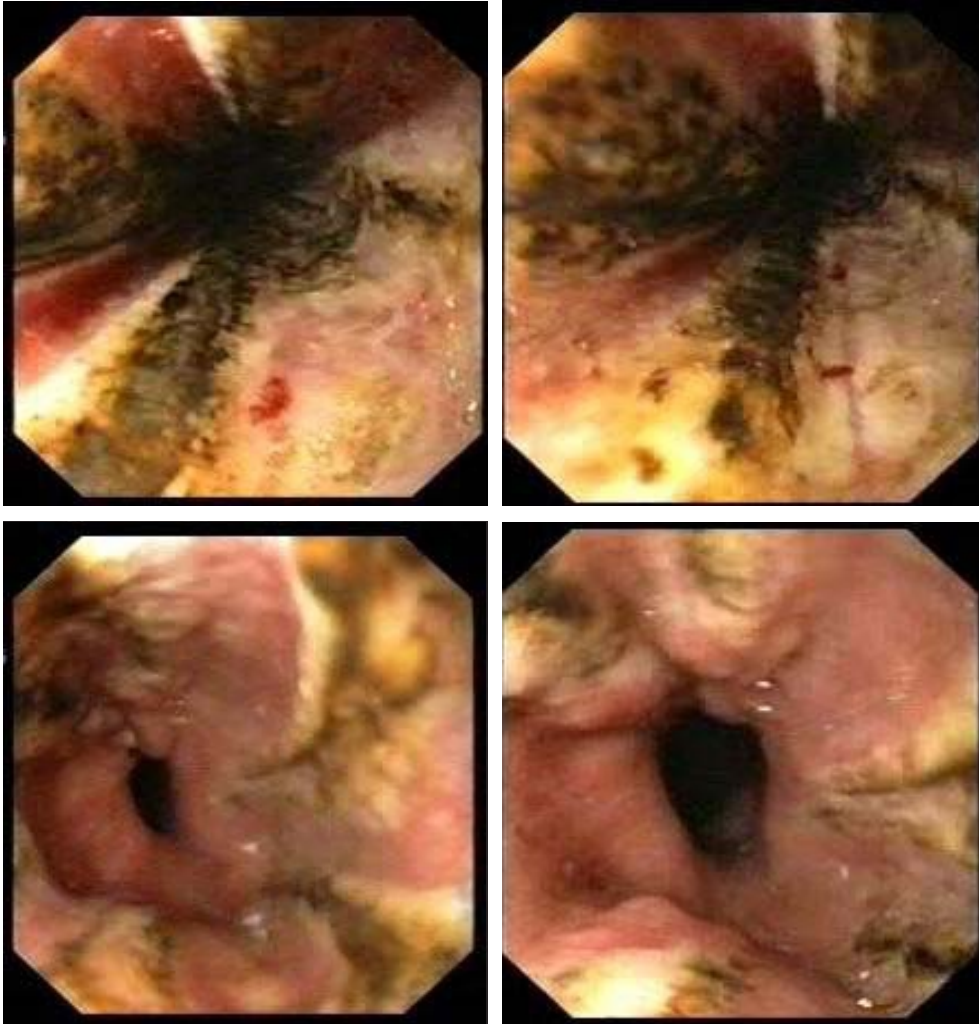


Figure 6

The EGD showed diffuse circumferential erosive esophagitis with inflamed of the surrounding mucosa and blood clot stained on the mucosa which represented of recent bleeding episode. This was a characteristic of reflux esophagitis with LA. classification grade D as shown in the table. Proton-pump inhibitor was given as the treatment of choice.

Los Angeles Endoscopic Grading Scheme for Esophagitis Severity; LA. classification

Grade A - one or more mucosal breaks each < or

= 5 mm in length.

Grade B - at least one mucosal break >5 mm long, but not continuous between the tops of adjacent mucosal folds

Grade C - at least one mucosal break that is continuous between the tops of adjacent mucosal folds, but which is not circumferential .

Grade D - mucosal break that involves at least three-fourths of the luminal circumference .