Can the stomach be a target of cap polyposis?

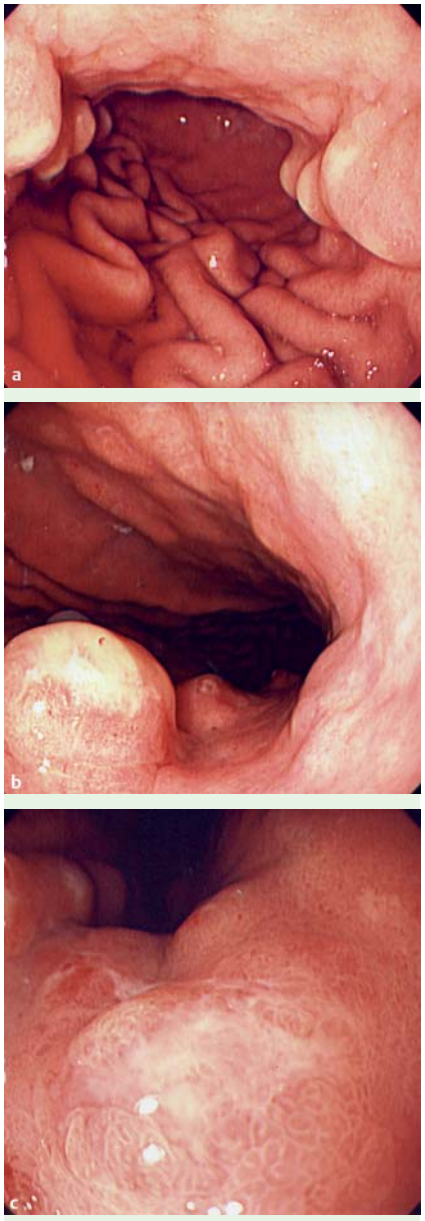

Fig. 1 **a, b** Gastroscopic view of the stomach showing multiple, variable-sized polyps on the posterior wall and lesser curvature of the upper body, as well as multiple, small, irregular nodular lesions all over the upper part of the gastric mucosa. **c** Gastroscopic view of the lesions showing sessile polyps with central ulceration and a thick mucoid exudative cap.

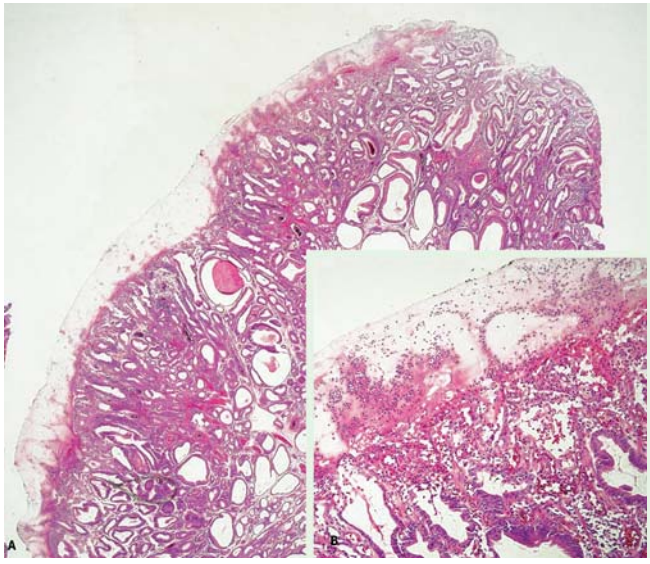

Fig. 2 **a** Photomicrograph of a gastric polyp showing irregular proliferation of crypts and chronic inflammation (hematoxylin and eosin [H&E], magnification × 12.5). **b** Higher power view of the polypoid lesion showing the eroded surface covered with granulation tissue and acute inflammatory exudates (H&E, magnification × 200).

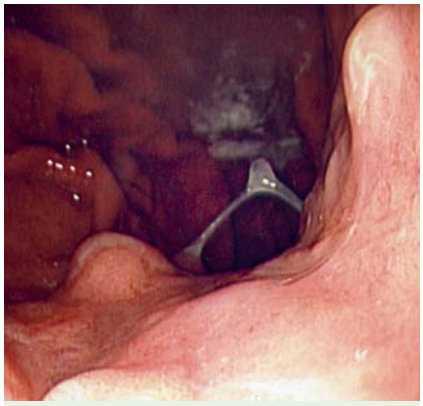

Fig. 3 Gastroscopic view of stomach 4 months after *Helicobacter pylori* eradication, showing multiple, sessile polyps, slightly smaller than before and covered with mucoid caps.

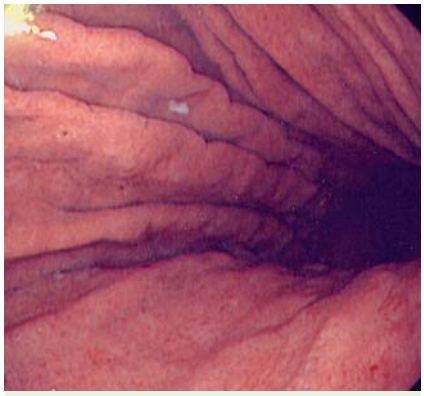

Fig. 4 Gastroscopic view of stomach 16 months after *Helicobacter pylori* eradication showing no mucosal abnormality.

A 67-year-old woman presented with epigastric pain and nausea. Gastroscopy showed multiple, variable-sized nodules on the posterior wall and lesser curvature of the upper body of the stomach. Grossly, the lesions resembled sessile or semi-pedunculated polyps, and on closer look, they showed central ulceration with a thick mucoid or fibropurulent exudate (▶ **Fig. 1**).

To confirm the diagnosis, we performed endoscopic mucosal resection and removed one lesion. The *Campylobacter*-like organism (CLO) test was positive. Microscopic examination of the gastric polyp showed irregular proliferation of crypts accompanied by chronic inflammation. The surface of the polyp was eroded and covered by granulation tissue and acute inflammatory exudates (▶ **Fig. 2**).

Colonoscopic findings were unremarkable. The patient was given *Helicobacter pylori* eradication treatment. Four months after *H. pylori* eradication, gastroscopy was carried out again. Multiple, sessile or semi-pedunculated polyps were still noted on the upper body of the stomach but the size of the lesions had decreased slightly (▶ **Fig. 3**).

The rapid urease test was negative. The patient attended our hospital again 16 months after *H. pylori* eradication. She denied having abdominal pain, nausea, or vomiting. On gastroscopy, the lesions described above were no longer seen (▶ **Fig. 4**).

The CLO test was negative.

Cap polyposis, first described by William and Morson in 1985, is a rare disease with unique clinicopathologic features [1]. It commonly affects the sigmoid co-

lon and rectal mucosa [2]. The characteristic endoscopic feature is the presence of multiple, sessile polyps covered by an apical "cap" consisting of mucoid and fibropurulent exudates [3]. Recently, Oiya et al. reported a case of colonic cap polyposis with similar lesions in the stomach [4]. After *H. pylori* eradication treatment, all colonic and gastric lesions were healed [4,5].

Here, we report a case of gastric cap polyposis with no evidence of colonic lesions, cured by *H. pylori* eradication treatment. *H. pylori* eradication treatment may be beneficial in patients with gastric cap polyposis, avoiding the need for endoscopic or surgical intervention.

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S. Y. Yang[1], **S. I. Choi**[2]

[1] Department of Gastroenterology, Dongnae Paik Hospital, Inje University College of Medicine, Geumjung-Gu, Busan, South Korea

[2] Department of Pathology, Dongnae Paik Hospital, Inje University College of Medicine, Geumjung-Gu, Busan, South Korea

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Bibliography
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Corresponding author
S. Y. Yang, MD, PhD
Department of Gastroenterology
Dongnae Paik Hospital
Inje University College of Medicine
Bugok 3-Dong
Geumjung-Gu
Busan 609-819
South Korea
Fax: +82-51-5122966
ysydr@dreamwiz.com