60 ANOS ARQUIVOS DE GASTROENTEROLOGIA

E-VIDEO

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Chronic anemia caused by giant and solitary Peutz-Jeghers hamartomatous polyp treated by endoscopic resection

Fernando **RODRIGUEZ-GUZMAN**[1], Jennifer Nakamura **RUAS**[1], João Guilherme Guerra De Andrade Lima **CABRAL**[1], Otavio **MICELLI-NETO**[1], Filadelfio Euclides **VENCO**[2] and José Celso **ARDENGH**[1,3]

[1] Hospital Moriah, Serviço de Endoscopia Digestiva, São Paulo, SP, Brasil. [2] Faculdade de Medicina da Universidade de São Paulo, Departamento de Patología, São Paulo, SP, Brasil. [3] Hospital das Clínicas da Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo, SP, Brasil.

HIGLIGHTS

- Giant and solitary polyps evolve with anemia.
- EUS is an important tool for stage and manage this disease.
- Endoscopic treatment is the best treatment choice.
- Supplementary video available on this case report.

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Corresponding author: Fernando Rodriguez-Guzman. E-mail: fer_nan_dojx_@hotmail.com

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The Peutz-Jeghers syndrome (PJS) is rare, autosomal dominant. It is associated with Peutz-Jeghers hamatomatous polyps (PHP), which affect any part of the alimentary tract associated with typical mucocutaneous pigmentation[1]. Recently, a patient with PHP without mucocutaneous pigmentation and a family with no history of PJS was described. It is suggested that this condition be considered as a different clinical entity from PJS[2]. The occurrence of solitary PHP in the duodenum is rare, and few reports describe its endoscopic characteristics[2-6]. It usually involves the duodenal bulb (70%), second (26%) and third portions of the duodenum in 4% of cases. Tumors ≥2.0 cm in diameter may present with hemorrhage, obstruction, and anemia.

The endoscopic mucosal resection (EMR) of this disease should be considered if intussusception, anemia, or if its size is >2.0 cm. Preoperative evaluation can be performed by imaging or endoscopic ultrasound (EUS). EMR can be diagnostic and/or therapeutic because it is minimally invasive. The authors report the case of a patient with a giant solitary polyp whose first endoscopic biopsy revealed a vilotubular adenoma. The solitary giant polyp was staged by EUS and treated by endoscopy.

62-year-old man with chronic anemia. After normal endoscopic exams, capsule endoscopy was indicated, which revealed a duodenal polyp confirmed by magnetic resonance imaging. The magnetic resonance imaging enterography showed thickening of the 3rd and 4th duodenal portions of 6.1 cm in length. A new endoscopy identified a polypoid, vegetating lesion of the 2nd duodenal portion with the biopsy revealing the presence of vilotubular adenoma. The polyp had a long, thick pedicle inserted 2.0 cm above the major duodenal papilla, confirmed by EUS, which revealed an oval, isoechoic, homogeneous lesion, with precise limits of 4.1 x 3.1 cm, with central vascularization

detected by positive Doppler (FIGURE 1). We then implanted an endoloop to cause ischemia in the cephalic portion of the polyp and prevent bleeding after removal (FIGURE 1a). With a 3.0 cm polypectomy snare, it was possible to remove the lesion and then recover it. Then, we closed the resection bed with a hemostatic clip (FIGURE 2). The monobloc was sent for histopathology, which revealed PHP (FIGURE 3).

The authors reported a rare case of giant PHP, not diagnosed preoperatively, which could only be accurately identified after EMR through histopathological analysis of the removed specimen. EUS associated with EMR should be considered even in tumors located in extremely unfavorable luminal portions of the upper digestive tract.

Authors' contribution

Rodriguez-Guzman F: Bibliographic survey and wrote the text. Ruas JN: bibliographic survey. Cabral JGGAL and Micelli-Neto O: edited the video. Venco FE: evaluated the pathological examination. Ardengh JC: Made all corrections.

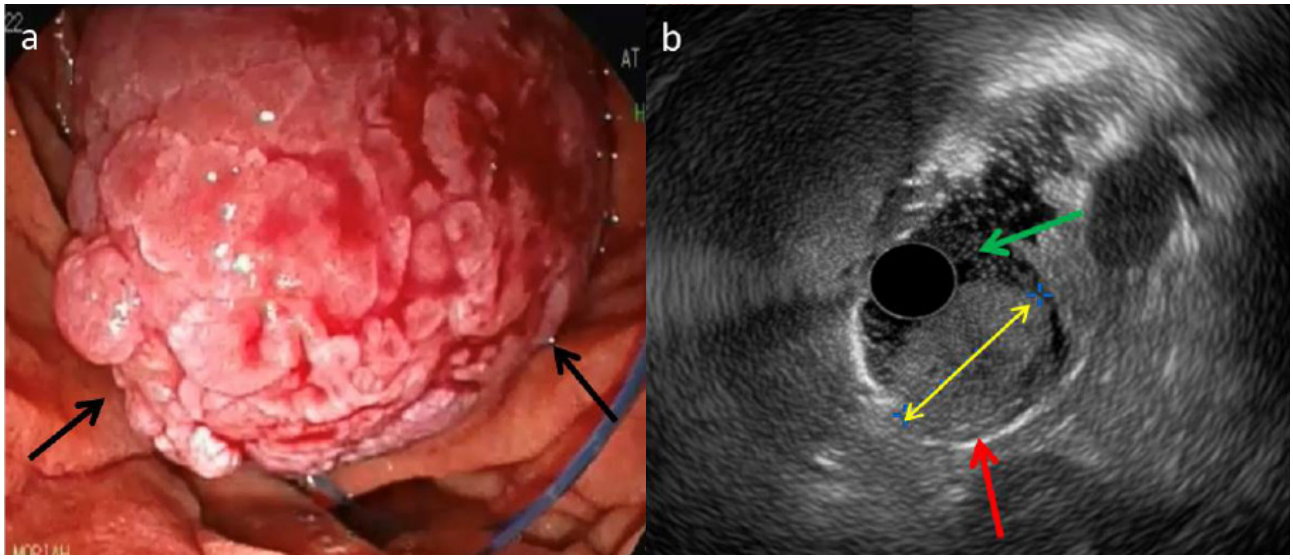

FIGURE 1. A) Endoscopic image of the polyp in the second duodenal portion (black arrows). **B)** EUS hypoechoic oval area, homogeneous with precise limits (yellow arrow). The pedicle (red arrow) and the duodenal lumen (green arrow) can be seen in this photo.

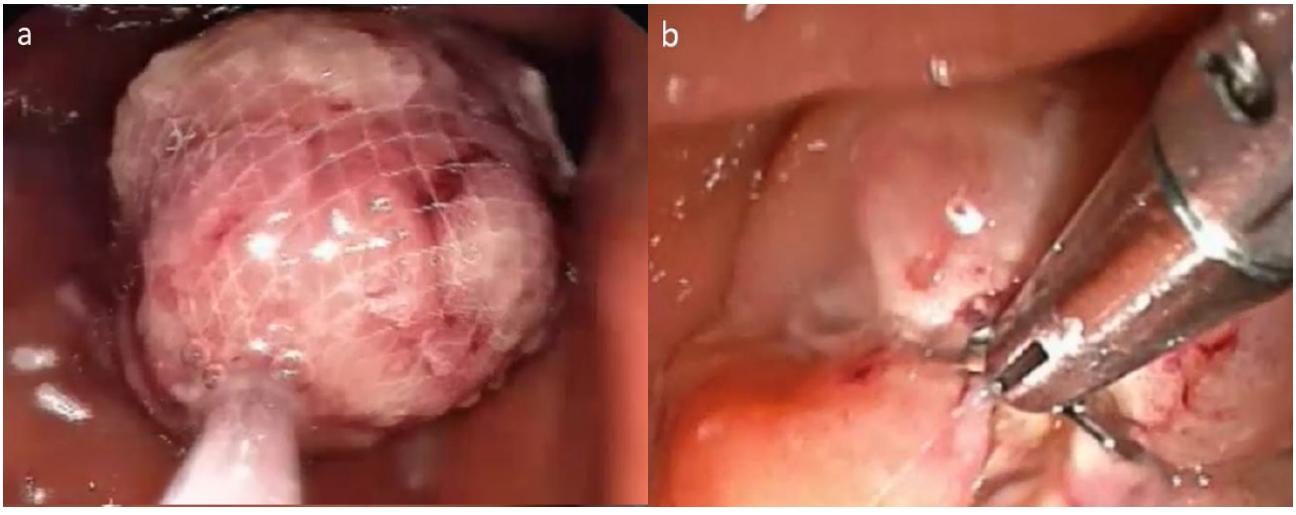

FIGURE 2. A) Moment of polyp seizure with rot net accessory. **B)** Image showing the closure of the bloody area created by EMR with endoclips.

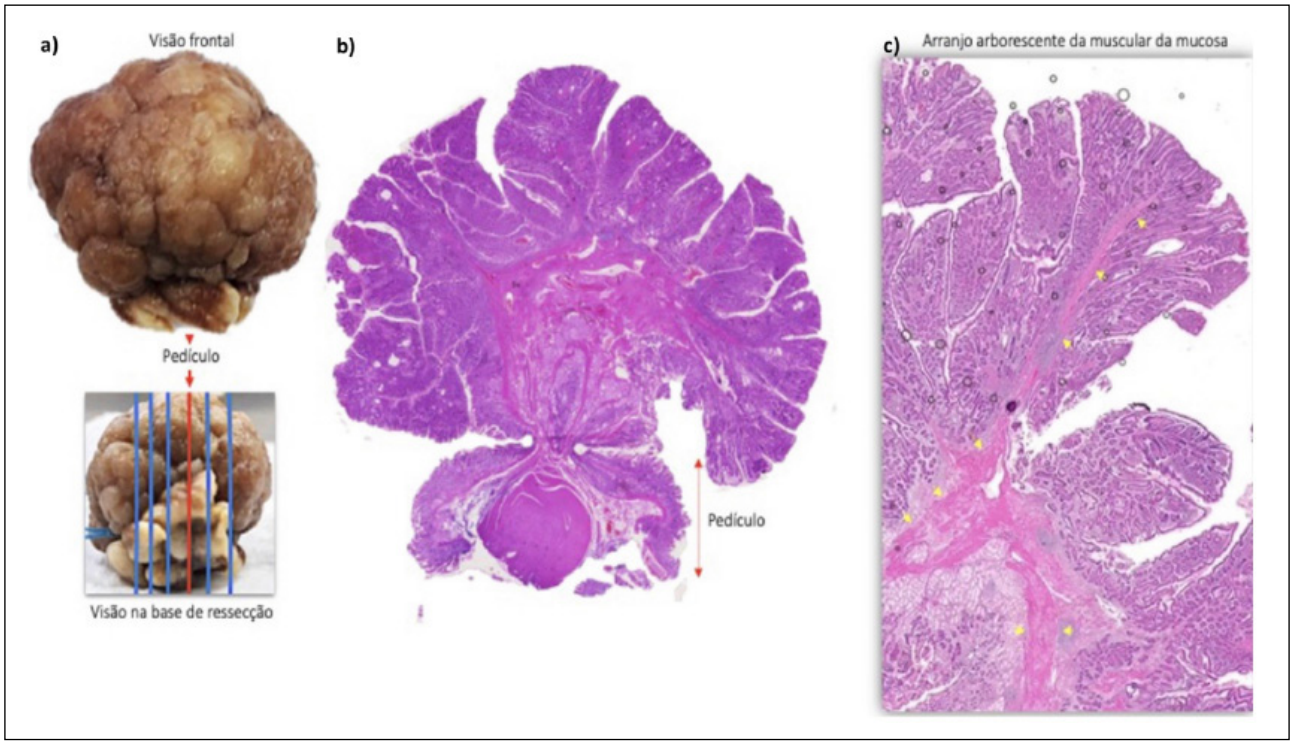

FIGURE 3. A) Macroscopy of the polyp measuring 3.5 x 2.5 cm with its pedicle. **B)** Image (200x) of the section represented by the line in red with the largest diameter of the polyp. Note irregular and diffusely dilated glands. **C)** At higher magnification, pseudostratified epithelium without atypia can be seen.

Orcid

Fernando Rodriguez-Guzman: 0000-0003-4358-6710.
Jennifer Nakamura Ruas: 000-0002-8095-6648.
João Guilherme Guerra De Andrade Lima Cabral: 0000-0001-7607-6982.
Otávio Micelli-Neto: 0000-0003-3803-5578.
Filadélfio Euclides Venco: 0000-0002-2986-1053.
José Celso Ardengh: 0000-0002-5932-2499.

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