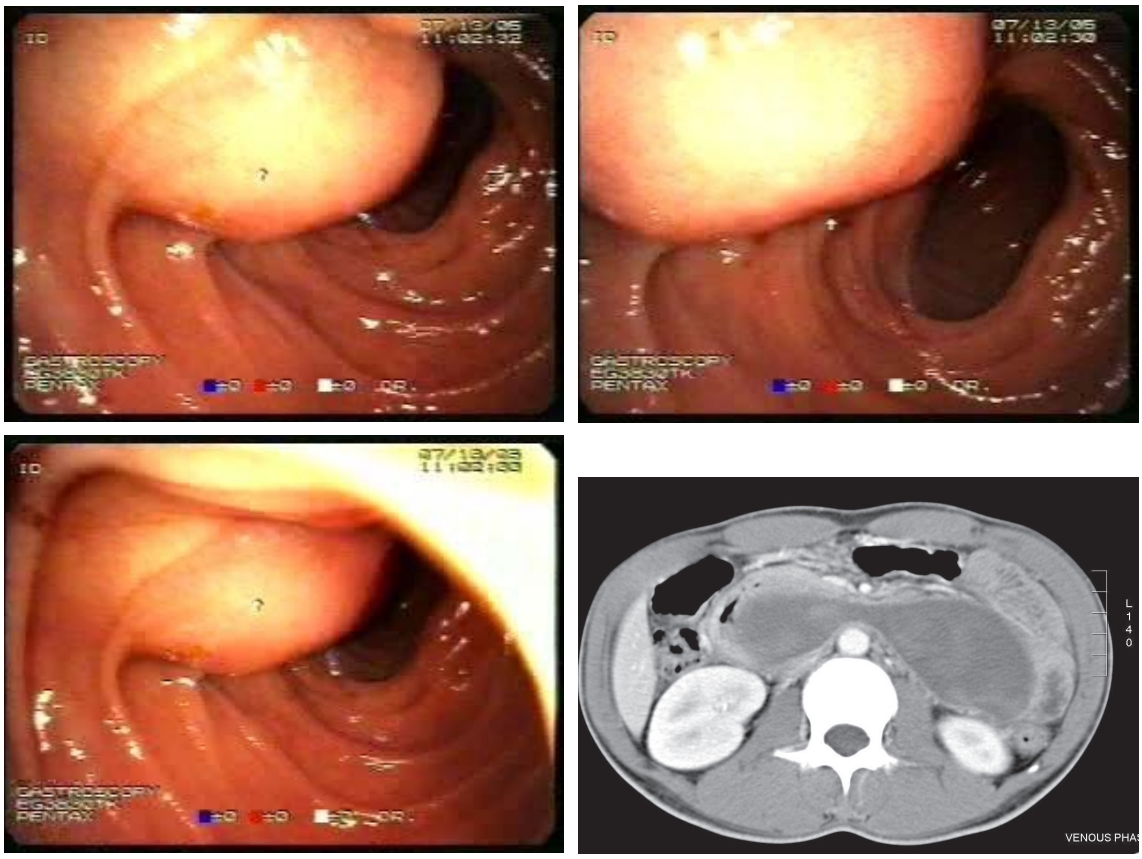
Digestive Endoscopic Corner

Panusit Petcharapirat, M.D.
Rungsun Rerknimitr, M.D.

Case 1

A 35 years old woman, present with postprandial vomiting and weight loss for 2 months. She had history of chronic heavy alcoholic drinking. EGD was done. What is the diagnosis ?



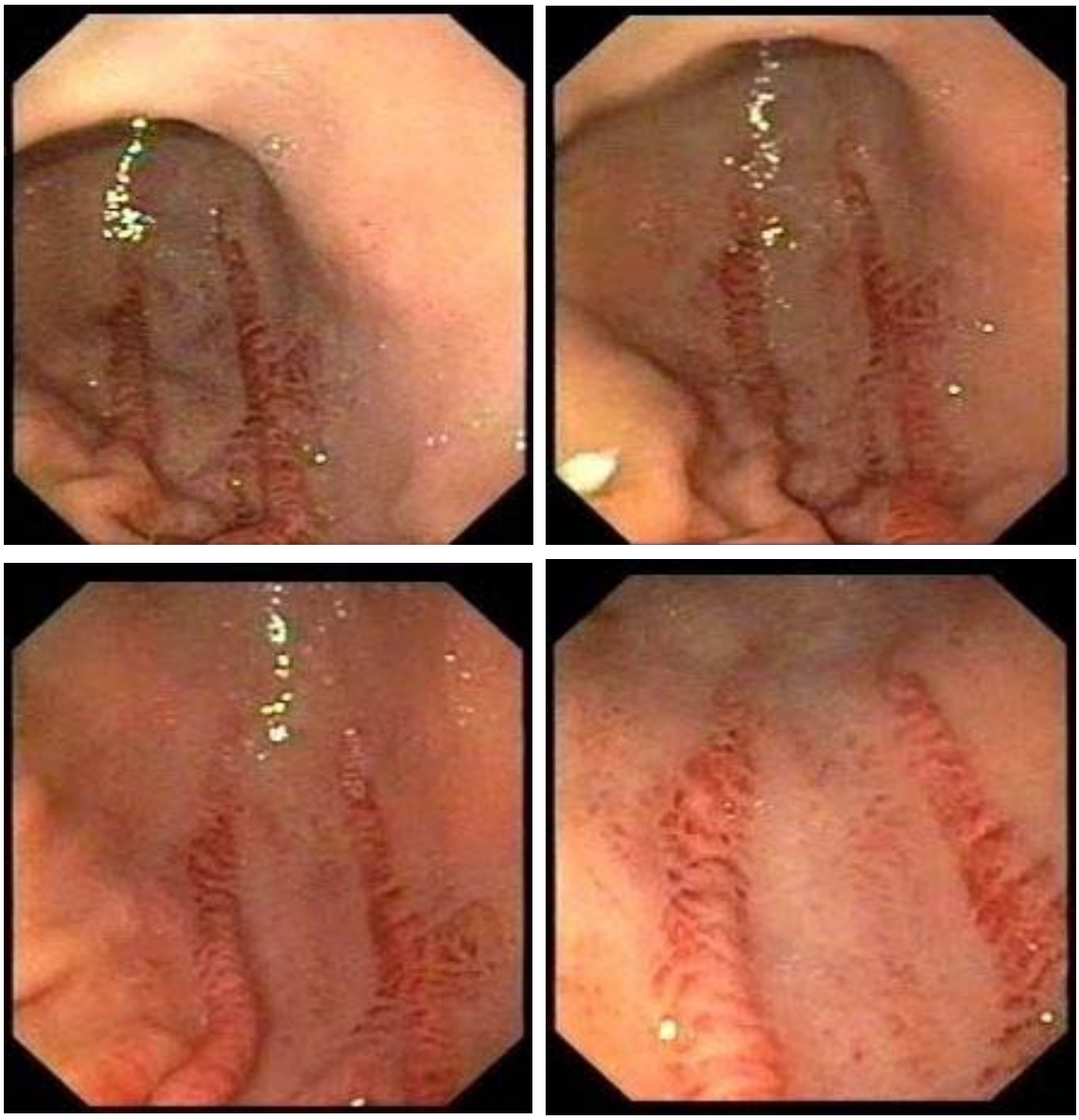
The EGD showed a larged, well-demarcated mass compressed the duodenal lumen at 3rd part of the duodenum caused partial duodenal obstruction. The differential diagnosis are submucosal tumor or extrinsic mass compression. Abdominal CT scan showed a larged partial formed pancreatic pseudocyst compressed the duodenal lumen. The patient was treated by conservative management without any pancreatic pseudocyst drainage procedure.

The follow - up CT scan showed the decreased size of pseudocyst and her clinical symptom was recovered within 3 weeks.

Gastroenterology Unit, Chulalongkorn University, Bangkok 10330, Thailand

Case 2

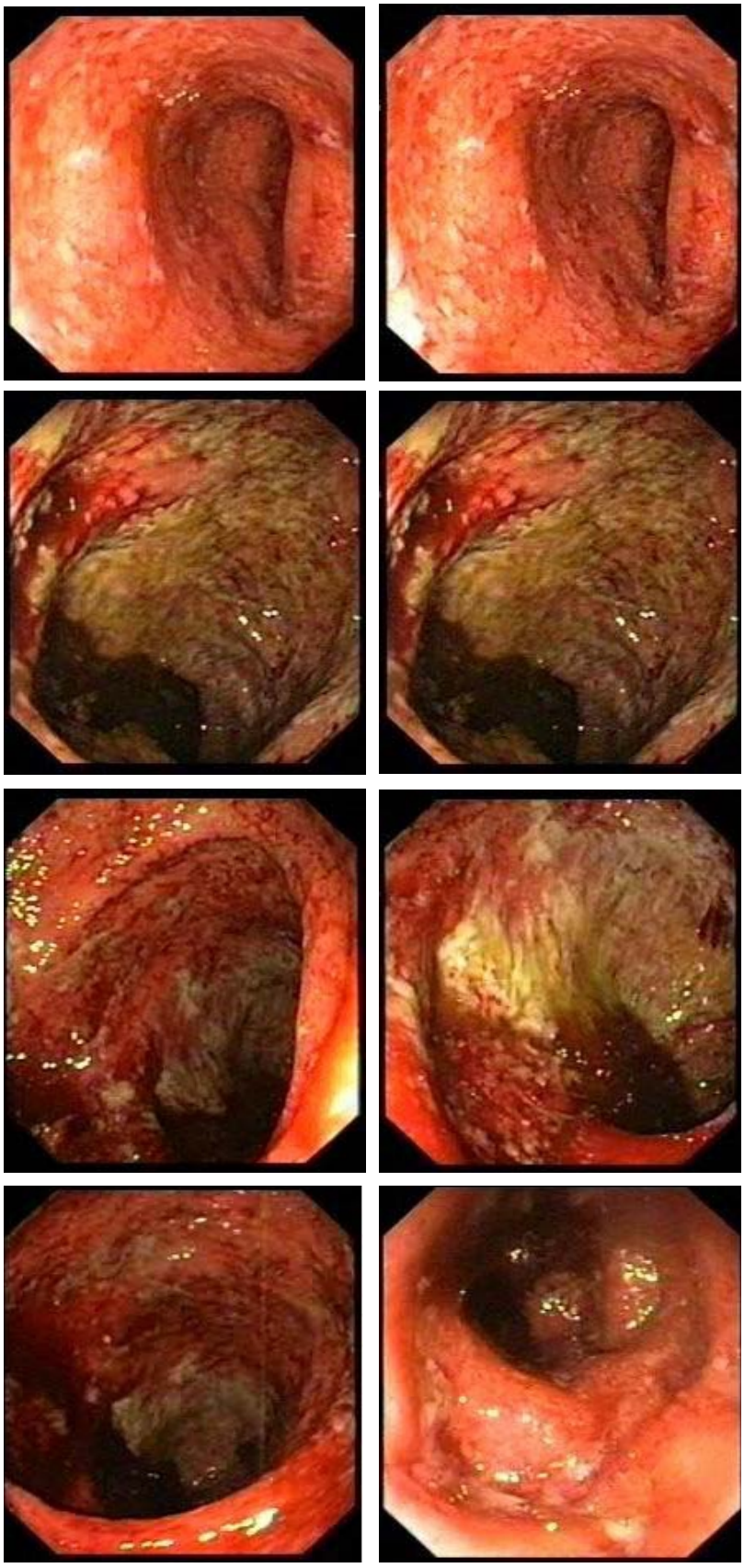
A 46 years old man with underlying PBC, present with anemia and positive stool occult blood test. EGD was done. What is the diagnosis ?



The EGD showed the array of tortuous, dilated vessels radiating outward from the pylorus, like spokes from the wheel, and resembling the dark stripes on the surface of the watermelon. This lesion is called Gastric Antral Vascular Ectasia (GAVE) or Watermelon stomach. The most common presenting symptom is obscure GI blood loss. GAVE is seen particularly in middle-aged or older women and associates with achlorhydria, atrophic gastritis, cirrhosis, the CREST syndrome, and seen after bone marrow transplantation. Microscopic features showed dilated capillaries with focal thrombosis, dilated and tortuous submucosal venous channels, and fibromuscular hyperplasia of the muscularis mucosa. Transendoscopic laser photocoagulation, Argon plasma coagulation and heater-probe therapy are being used with increasing success to treat GAVE.

Case 3

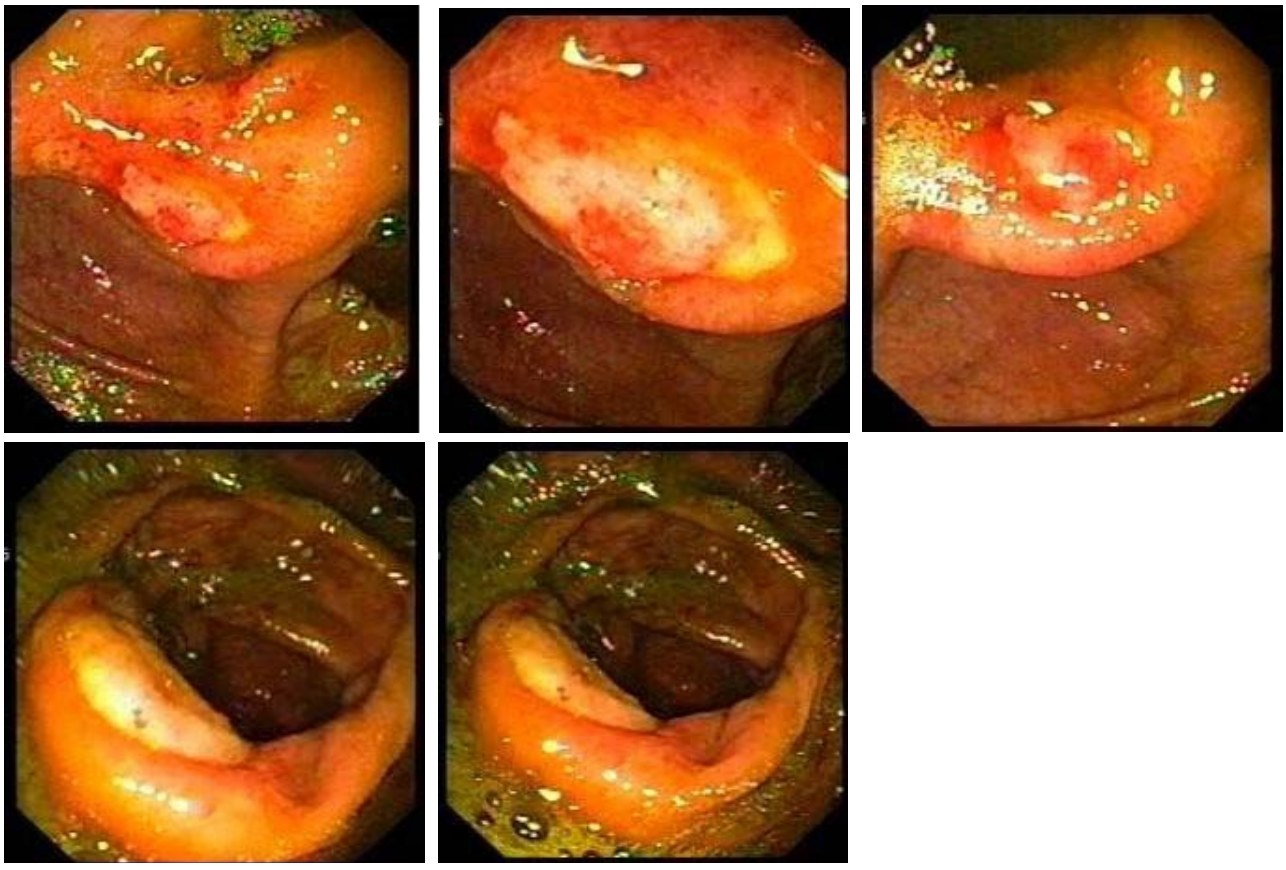
A 27 years old man present with LGIB and weight loss for 2 weeks. Colonoscopy was done . What is the diagnosis ?



The colonoscopy showed multiple small shallow ulcers with exudates extended from rectum to cecum. The surrounding mucosa showed loss of vascularity, granularity, diffuse hemorrhage, friable and spontaneous bleeding. The most likely diagnosis is severe ulcerative colitis or pancolitis. Although the differential diagnosis are infectious colitis, radiation colitis, ischemic colitis and pseudomembranous colitis but the pathological finding showed evidence of chronicity such as distorted crypt architecture, crypt atrophy, an irregular mucosal surface, basal lymphoid aggregation and a chronic inflammatory cells infiltration without any demonstrated microorganisms. The lack of predisposing factors for ischemic colitis and pseudomembranous colitis can help to diagnosis ulcerative colitis.

Case 4

A 40 years old man with advanced HIV infection, CD4 count = 74 /mm^3, present with chronic progressive RLQ pain. CT abdomen showed thickening of ascending colon and cecum. Colonoscopy was performed. Please describe the lesion and give the differential diagnosis.



The colonoscopy showed 2 large colonic ulcers contained hemocystic spot at base and erythematous, edematous rim. One colonic ulcers located at cecum and the other located at ascending colon, intervening with the surrounding erythematous mucosa. The ileocecal valve looked normal. The biopsy at base of ulcer was done and showed the evidences of intranuclear and intracytoplasmic inclusions in the lamina propia and mucosa with scattered neutrophil and chronic inflammatory cells infiltration. The immunohistochemical staining show positive stain for Cytomegalovirus. This patient was treated by intravenous Ganciclovir for 2 weeks and then switch to Valganciclovir, the new FDA - approved for CMV treatment in oral form.