Gastric Xanthoma (GX) as an Incidental Endoscopic Finding: A Report of 2 Cases

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Gastraic xanthomas (GXs) are yellow mucosal lesions characterized by the accumulation of lipid-laden histiocytes in the lamina propria. It is usually an incidental endoscopic finding of unclear clinical significance. It has a quite variable incidence that increases with age. GX was reported to be associated with chronic gastritis, hyperplastic polyps, gastric cancer, and H pylori infection. It has been hypothesized that GX could be related to gastric injury, which was supported by the higher prevalence of gastric atrophy among reported cases. Surprisingly, no correlation between GX and hyperlipidemia was found. Case 1: A 54 year-old Caucasian female with a history of primary pulmonary hypertension and ESRD post renal and bilateral lung transplant, admitted to the hospital with epigastric pain. Vital signs were normal, physical examination was significant for mild epigastric tenderness. Laboratory work and imaging was unremarkable and a CT scan was performed. EGD was not diagnostic, however given the clinical presentation and concern for GIST, patient endoscopy revealed a metastatic gastric mass. We think it is prudent to look for GX gastric part ner and always send for histologic confirmation. Case 2: This is an 82 year-old male with a significant history of DM II and renal cell carcinoma, who presented to our hospital with melena. On physical examination, he looked pale and tachycardic. Vital signs were stable, his labs were remarkable only for normocytic anemia (HB: 7.9 g/dL, MCV: 92 fL). EGD was performed next day and it revealed a mass in the gastric body and a small gastric antral polyp (Figure 2), both biopsied. Subsequently, pathology results showed clear cell carcinoma consistent with metastatic renal cell carcinoma (the mass). Gastric antral polyp biopsy was suggestive of gastric xanthoma, confirmed by immunohistochemical staining for CD68. Eventually, laparoscopic partial gastrectomy was performed successfully. GX is a rare condition of unknown etiology. There is increasing evidence on the association between GX and gastric injury. GX should be considered as a warning sign, to look for other concomitant serious conditions, most importantly gastric cancer. In our reported cases, there was no evidence of H pylori infection or primary gastric cancer, lipid profile was normal. However, the second patient endoscopy revealed a metastatic gastric mass. We think it is prudent to look for GX gastric partners and always send for histologic confirmation.
Most documented cases of intussusception occur in children (90%) rather than adults (10%). 95% of children have primary intussusception, whereby the etiology is benign and idiopathic without defined causes. In contrast, almost 90% of the cases of intussusception in adults are secondary to a pathologic condition that serves as a lead point, such as carcinomas, polyps, Meckel’s diverticulum, colonic diverticulum, strictures or benign neoplasms. Secondary intussusception is believed to initiate from any pathologic lesion of the bowel wall or irritant within the lumen that alters normal peristaltic activity and serves as a lead point, which is able to initiate an invagination of one segment (intussusceptum) of the bowel into the other (intussuscipien). Classic triad of cramping abdominal pain, bloody diarrhea and a palpable mass is rare in adults. Symptoms could range from nausea, vomiting, and gastrointestinal bleeding to a change in bowel habits, constipation or abdominal distension. CT scan is the most sensitive radiologic modality to confirm intussusception with a characteristic “target” sign when the intussusception is perpendicular to the long axis or a “sausage” sign when it is parallel to the long axis. Intussusception in adult needs surgical resection or investigation given the high risks of secondary causes such as neoplasm.

(A) portable Chest x-ray (CXR) revealing left hemi-thorax findings were suspicious for left diaphragmatic hernia containing bowel loops. (B, C, D) Axial and Coronal contrast-enhanced CT scan of the Abdomen with 3D reconstruction showing left hemi-diaphragm defect with a large portion of the stomach herniating through it. (L: liver; St: stomach; K: kidney, Sp: spleen).

EGD findings: (A) ulcerative esophagitis. (B and C) Endoscopic exam of the stomach fundus showed hyperemic gastric mucosa, with two outlet channels, one of which was blind and other one was going into the pylorus with significant looping through this area. (D) pylorus. (E) Pyloric sphincter (F) Duodenum.