UNCOMMON ENDOSCOPIC FINDINGS

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ALBERTA SOCIETY OF ENDOSCOPIC PRACTICE
ASEP

COI Declaration

- None

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Objectives

1. To discuss uncommon endoscopic findings during endoscopy

2. To recognize the significance of these findings to ensure appropriate diagnosis, workup and patient management

Esophagus

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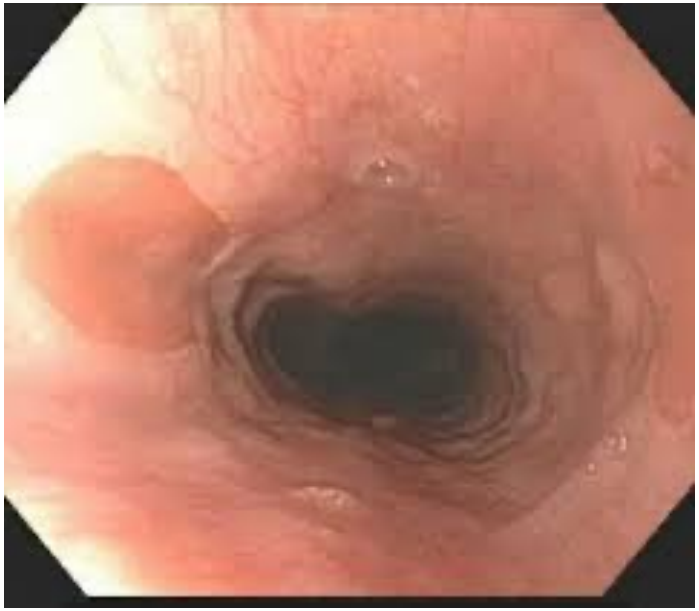
Case 1

- A 55yo male presents with refractory GERD, not responding to PPI
- No alarm features noted, normal lab work
- Normal UGI series aside from a small hiatus hernia
- No contributory PMHx
- EGD
  - no evidence of erosive esophagitis
  - Found to have “proximal Barrett’s esophagus”



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Case 1

- **Esophageal inlet patch**
  - Heterotopic gastric mucosal in the proximal esophagus
    - Resembles a discrete area of gastric mucosa
    - Up to 5% of patients undergoing EGD
  - Not clinically significant, as it is not related to any metaplastic or dysplastic risk for the patient
  - Reports of H.pylori infection and ulceration
    - Rx is the same as for PUD, with PPI and Hp eradication
  - Otherwise → No need to bx or followup

Case 2

- 78 yo female referred for dysphagia to solids
- Reports reflux/regurgitation of undigested food and pills
- No alarm features reported
- Occasional coughing/choking reported with swallowing
- Attempted gastroscopy at another centre
  - Failed due to “proximal esophageal stricture”
  - Referred to my care for consideration of dilation of the stricture

Case 2

- Endoscopic fi

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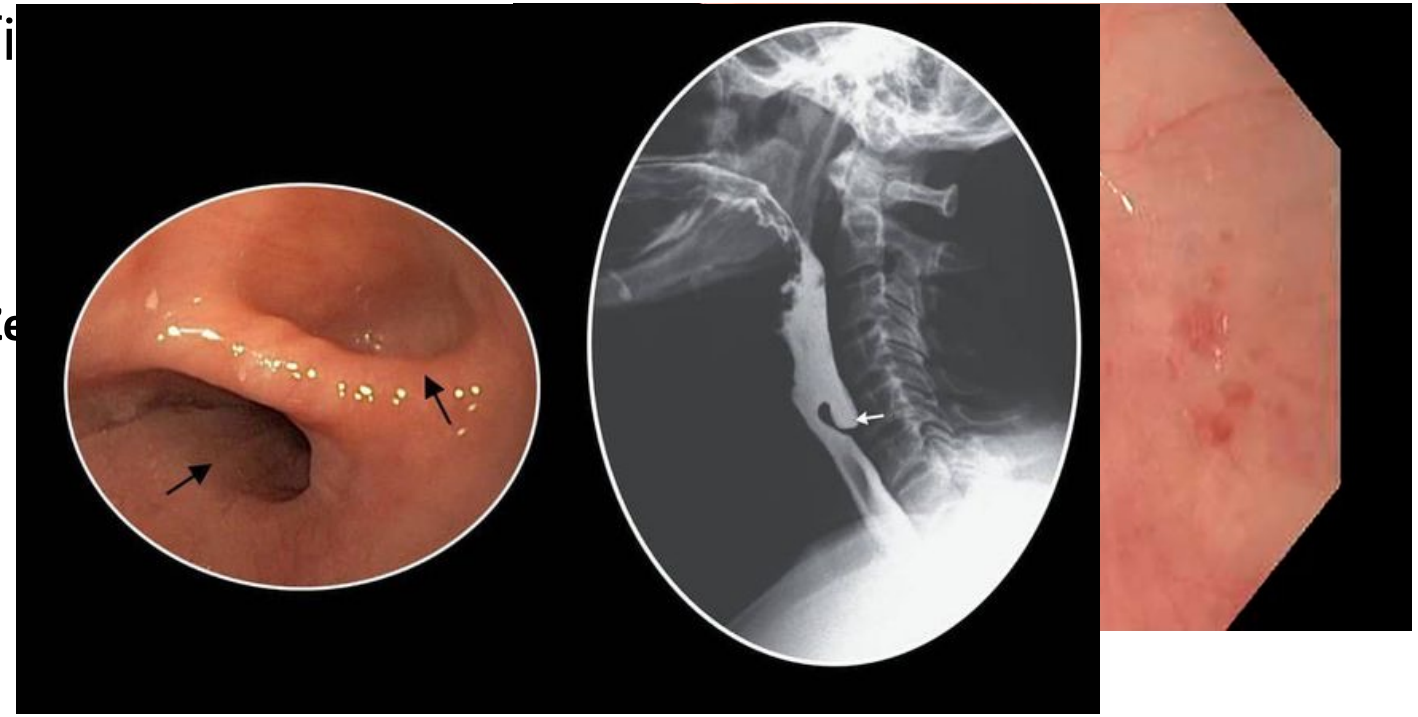

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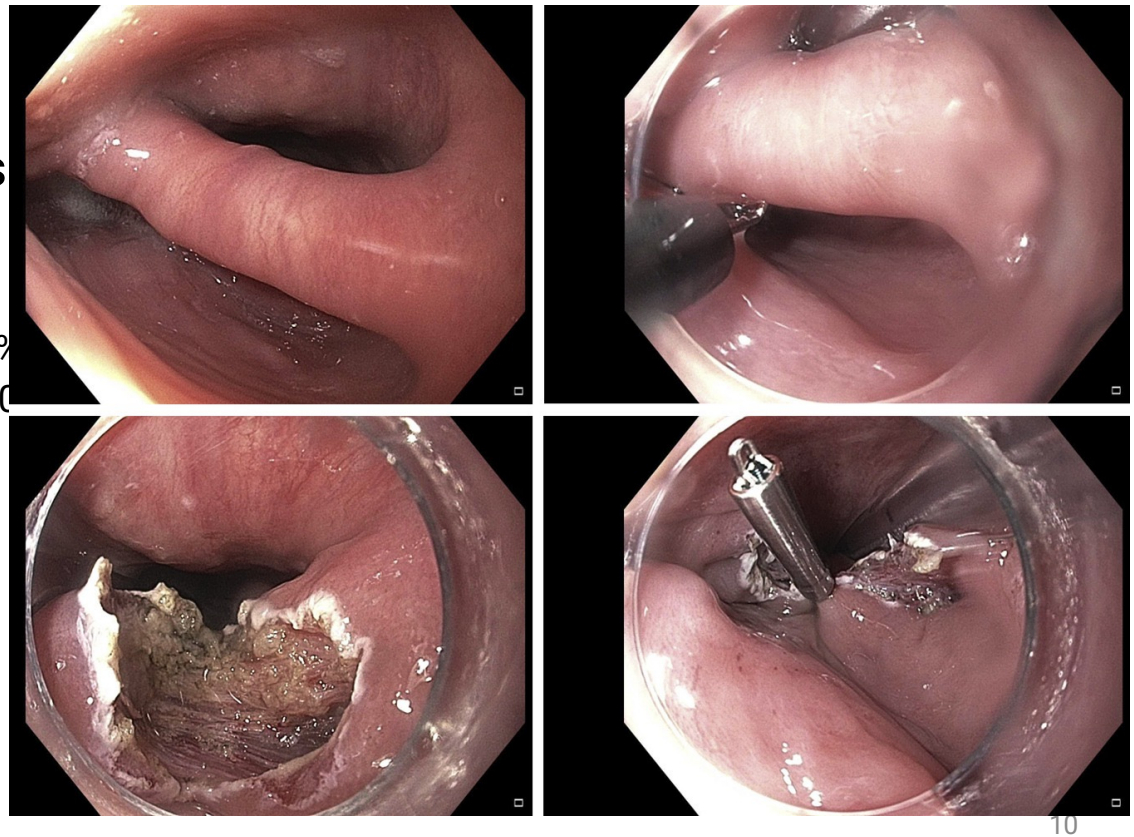
Case 2

- **Zenker's diverticulum**
  - Outpouching of the mucosa lateral to the cricopharyngeal muscles of the UES
    - "False diverticulum" – only contains mucosa and submucosa
  - Occurs in up to 0.1% of the population, male predominant (5x risk vs females)
  - Typically occurs in meddle ages to older patients (7^{th}/8^{th} decade)
  - Cause – hypertensive UES (cricopharyngeal bar) and natural weakness in Killian's Triangle
  - **Presentation** - *Often Asymptomatic*
    - Oropharngeal dysphagia 80%
    - Regurgitation of pills, food
    - Halitosis, wt loss, malnutrition

Case 2

- **Zenkers Rx**
  - Surgical – ENT open neck diss
  - Endoscopic
    - Septotomy
      - Improvement reported in 85-90%
      - Complication rate of 5-7% (vs 10



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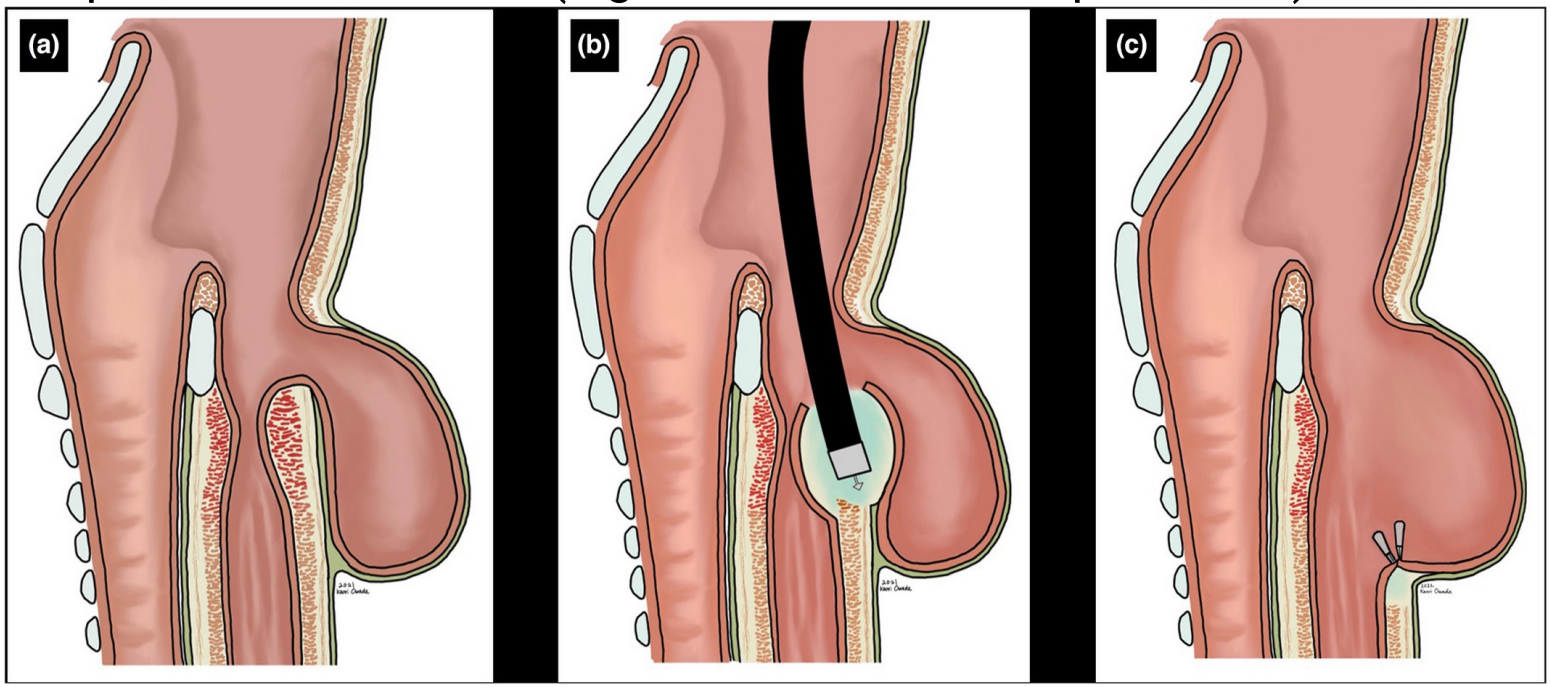
Case 2

- Zenkers Rx
  - Surgical – ENT open neck dissection (significant risk of complications)
  - Endoscopic
    - Septotomy
    - Z-POEM



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Stomach

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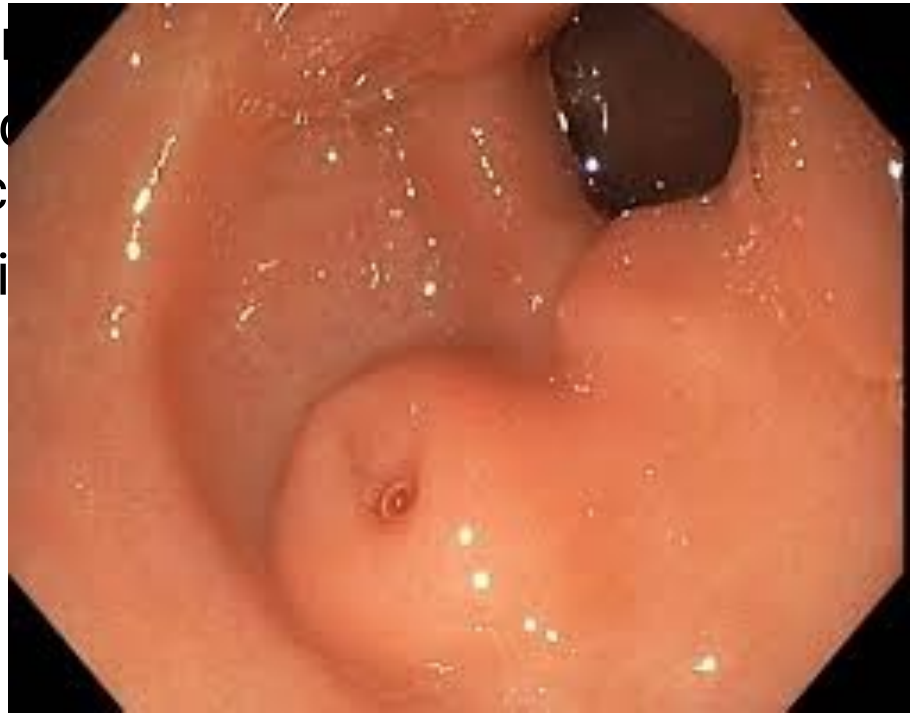
Case 3

- 37F with mild iron deficiency ane
- Found to be Anti-TTG positive an
  confirmation of suspected Celiac
- This was found during endoscopi

Pancreatic Rest Lesion→



Case 3

- **Pancreas Rest**
  - Ectopic / Heterotopic pancreatic tissue
  - Rare submucosal lesion of pancreatic exocrine and endocrine cells
  - Typically 1-1.5cm and ovoid in shape
  - Often found in the distal stomach but can also be found in the proximal small bowel as well
  - Normal overlying mucosa, but may have a prominent central dimple noted

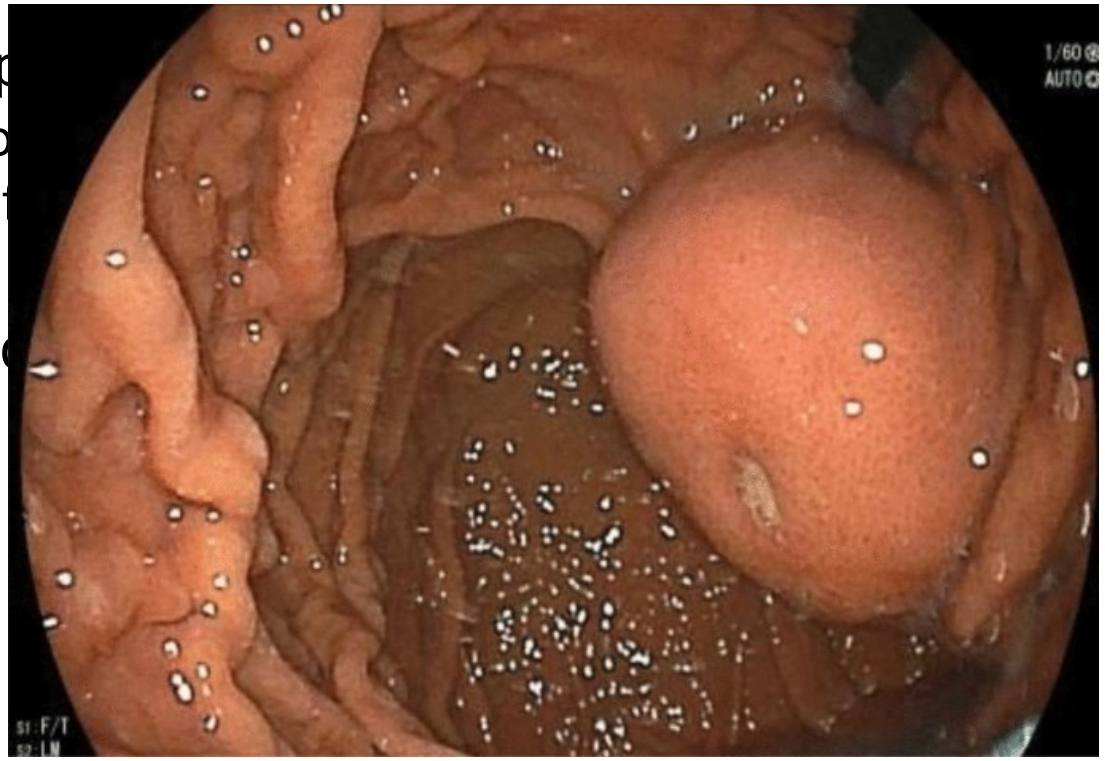
Case 3

- **Pancreas Rest**
  - Most commonly incidental finding, asymptomatic
  - Can occasionally be associated with pancreatitis, especially if excessive endoscopic manipulation occurs
    - No need to bx unless there is a clinical concern
    - EUS is first line choice for tissue acquisition
  - Rare documented cases of transformation to adenocarcinoma

  - Bottom line – leave them alone unless there is significant reason for further investigation, then refer for an EUS

Case 4

- 65yo male presented to p
  - Hb 98 (normal MCV) – no
  - Regular use of ibuprofen f
  - Non-smoker, no previous
- Referred for urgent EGD
- Endoscopy showed….



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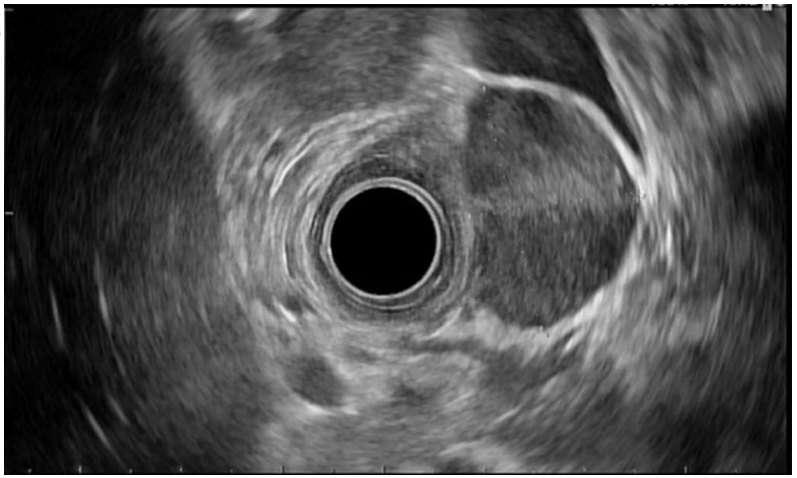
Case 4

- Endoscopy showed a 4cm submucosal lesion with an overlying deep ulcer
  - No active bleeding
  - No mucosal abnormality adjacent to the ulceration
  - Firm to palpation with CLOSED Bx force
- Next step?
  - EUS



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Case 4

- Endoscopy showed a 4cm subucosal lesion with an overlying deep ulcer
  - No active bleeding
  - Firm to palpation with CLOSED Bx forceps
- Next step?
  - EUS
    - 3.8cm lesion originating from muscularis propria
    - Homogenous in nature, no calcifications
    - FNB – spindle cells noted with CD117 positivity

Case 4

- **Gastrointestinal Stromal Tumor (GIST)**
  - Rare submucosal neoplasm of the GI tract – typically originate in the MP
    - Represent <1% of GI malignancy
  - Can occur anywhere and often are an incidental findings (especially small)
  - Large tumors can ulcerate and bleed, cause pain or even potential obstruction (direct or intussusception)
  - **Dx CT and EUS**
    - Larger size, heterogenous appearance and calcification often associated with higher risk of malignancy
    - EUS FNB – characteristic spindle cells with KIT positive (CD-117) staining

Case 4

- **GIST Rx**
  - Small (<2cm)or asymptomatic
    - Confirm dx with EUS FNB
    - Conservative Rx with serial imaging, EUS follow up
  - Large (>2cm) or symptomatic
    - Surgical excision

Colon

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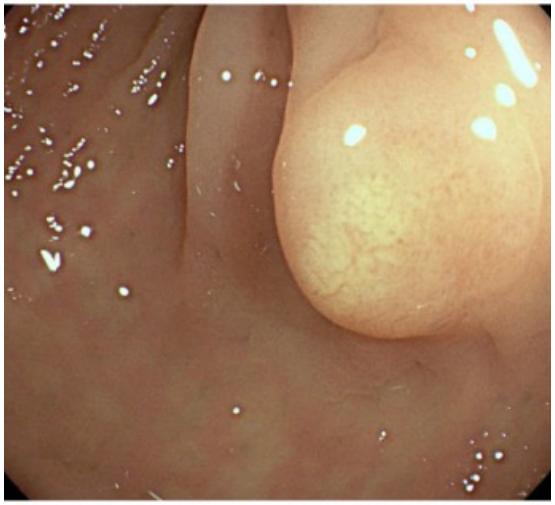
Case 5

- 55yo M, FIT positive referred to SCOPE for screening colonoscopy
- Asymptomatic, no family history or comorbidities
- Endoscopically found to have one small 8-9mm rectal polyp
  - removed with a cold snare en bloc
  - Concerns?



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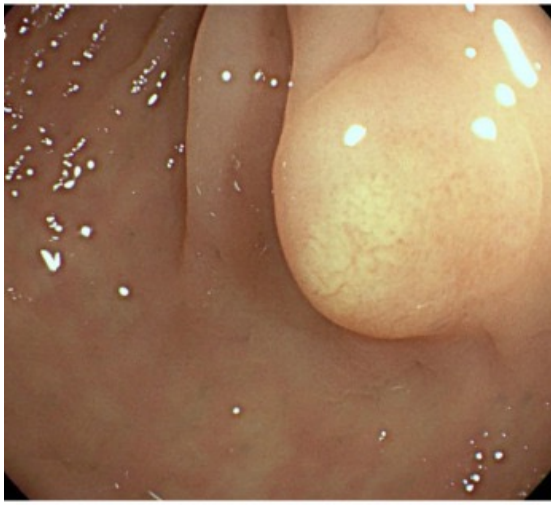
  - Concerns?

  - Dx – well differentiated neuroendocrine tumor (NET)



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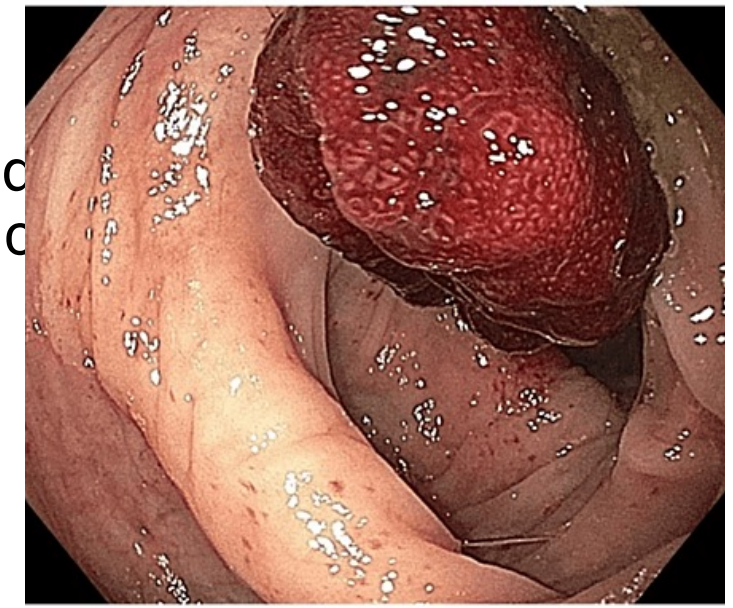
Case 5

- **GI NET**
  - Can occur anywhere along the GI tract with variable clinical presentation depending on the size, metabolic activity and location
- **Rectal NET**
  - Often <1cm, incidental findings
  - Yellowish coloration with no mucosal hyperplastic or adenomatous features
  - Typically well differentiated with very low risk for metastatic spread
    - <2% risk of metastasis if lesions <2cm and confined to the submucosa
  - Treatment – conventional **en bloc** polypectomy or advance mucosal resection
  - For lesions >2cm consider F-dopa PET/Dotatate scan to rule out metastatic spread prior to surgical referral

Case 6

- 72yo male with a known history of adenomatous polyps and sigmoid diverticulosis
- Patient asymptomatic
- Recent screening colonoscopy demonstrated erythematous sigmoid polyp, referred to my c
- Thoughts?



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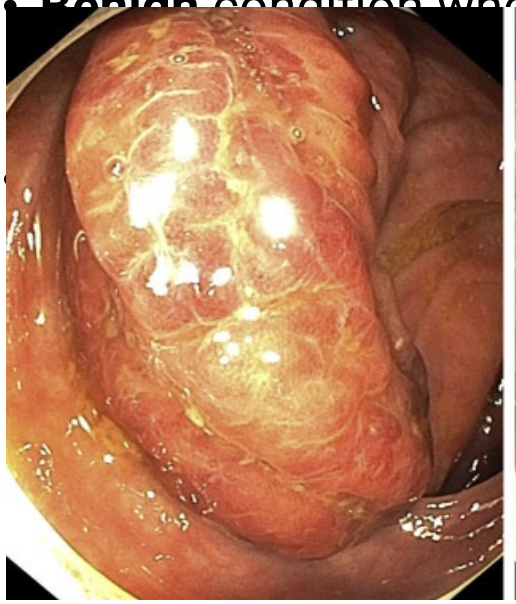
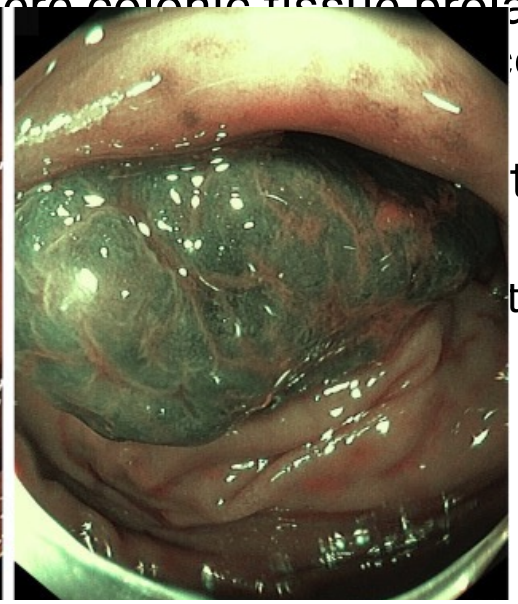
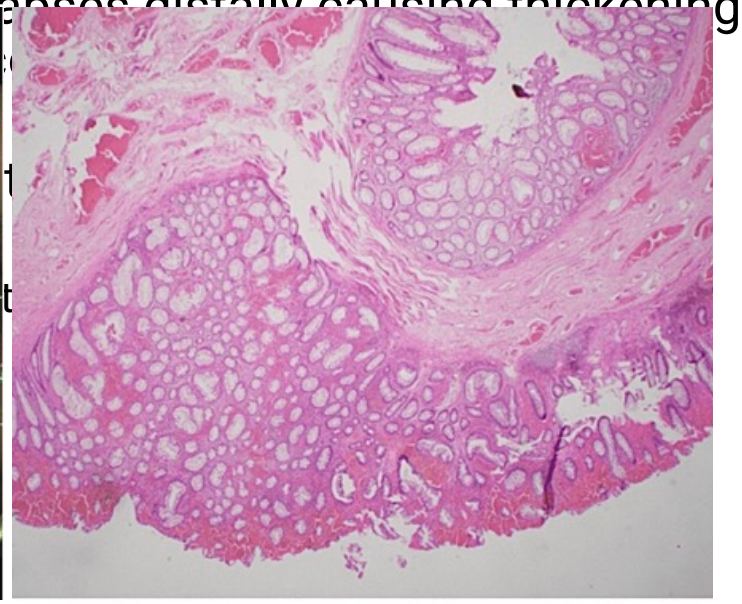
Case 6

- **Mucosal prolapse syndrome**
  - **Benign** condition where colonic tissue prolapses distally causing thickening,

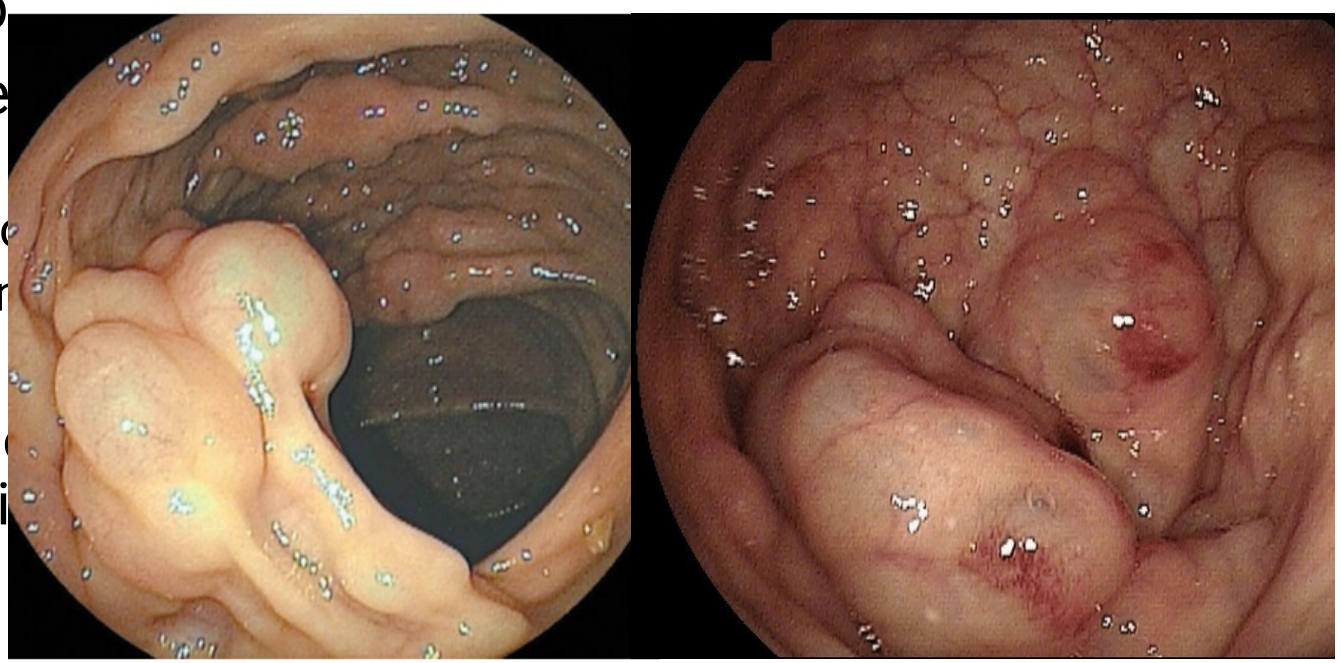




Case 6

- **Mucosal prolapse syndrome**
  - **Benign** condition where colonic tissue prolapses distally causing thickening, erythema and potentially ulceration, most commonly seen in the sigmoid colon and rectum
  - Can easily be mistaken for a polyp while in the sigmoid colon
    - Lacks pit pattern abnormalities associated with adenomatous polyps
    - Bx demonstrated fibromuscular hypertrophy of the lamina propria
    - Does **NOT** require EMR but if extensive ulceration/inflammation, or concerns for intussusception, refer for surgical resection

Case 7

- 71yo female FIT p
- Referred for scree
  - Asymptomatic
  - No Family Hx repo
  - No previous color
  - Known history of
- Found to have a c
  sigmoid/descendi



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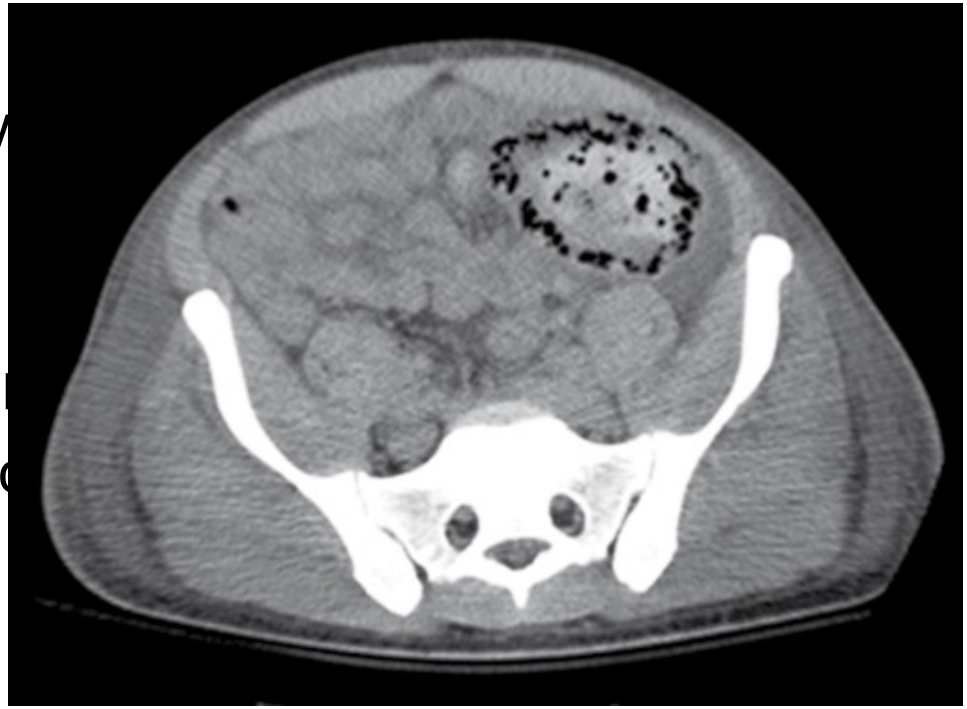
Case 7

- 71yo female FIT positive
- Referred for screening colonoscopy
  - Asymptomatic
  - No Family Hx reported
  - No previous colonoscopy
  - Known history of emphysematous CO
- Found to have a concerning submuc
  sigmoid/descending colon
- CT abdomen ordered the same day



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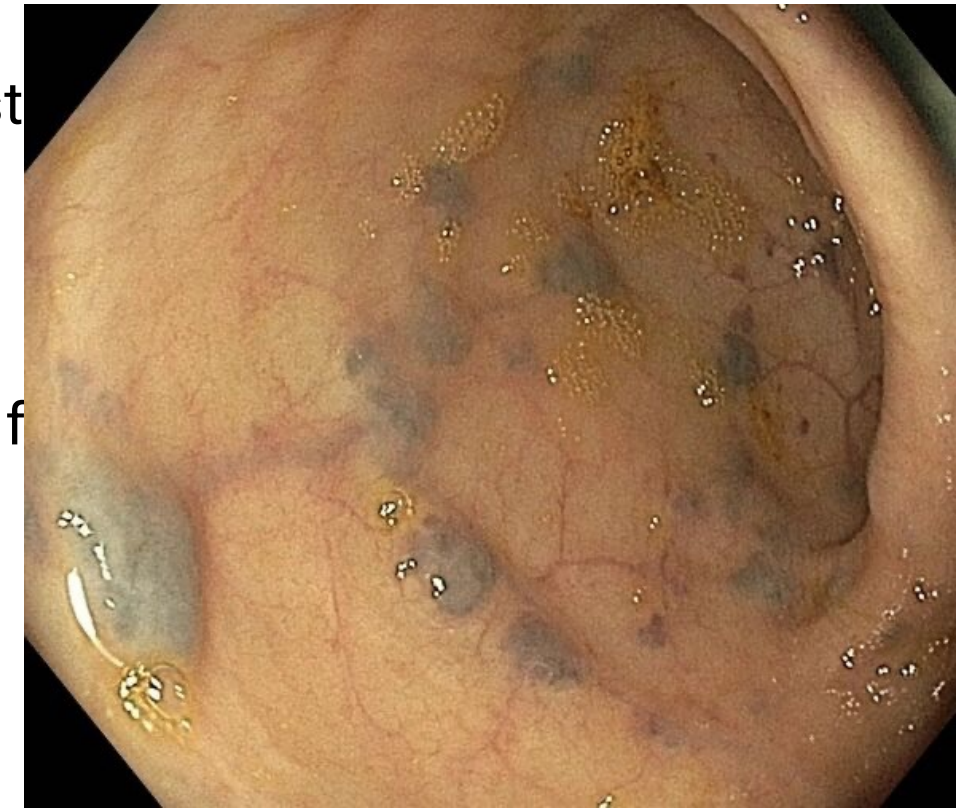
Case 7

- **Pneumatosis Cystoides Coli (PCC)**
  - Rare condition where gas-filled cysts form in the colon wall
    - Often incidentally found on colonoscopy or CT scan but patient can present with a constellation of GI symptoms including abdominal pain, diarrhea, fever, obstruction or perforation
  - **Benign/Idiopathic**: Pulmonary diseases (COPD), connective tissue disorders (scleroderma, lupus)
  - **Serious**: Bowel obstruction, intestinal ischemia, IBD, infection.
- **Treatment**
  - Aimed at treating the underlying cause
  - If incidental/benign, no treatment is needed.

Case 9

- 54M with recent FIT positive test
  colonoscopy
- No medical comorbidities
- Unknown family hx (adopted)
- Colonoscopy demonstrated the f



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Case 9

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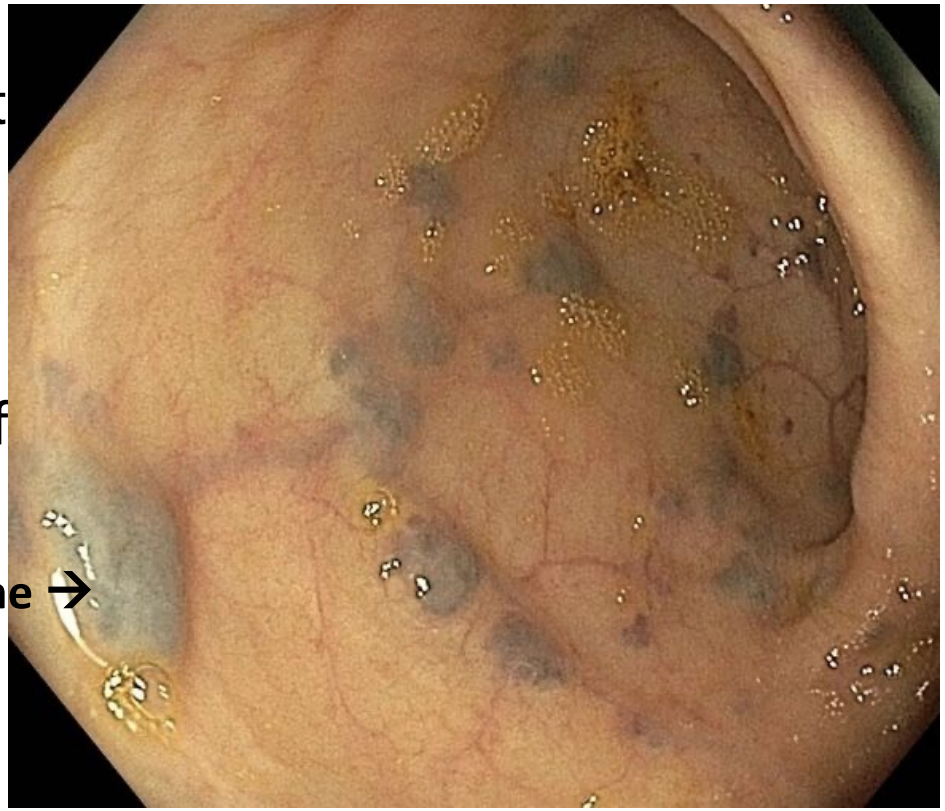
- Dx? **Blue Rubber Bleb Nevus Syndrome →**



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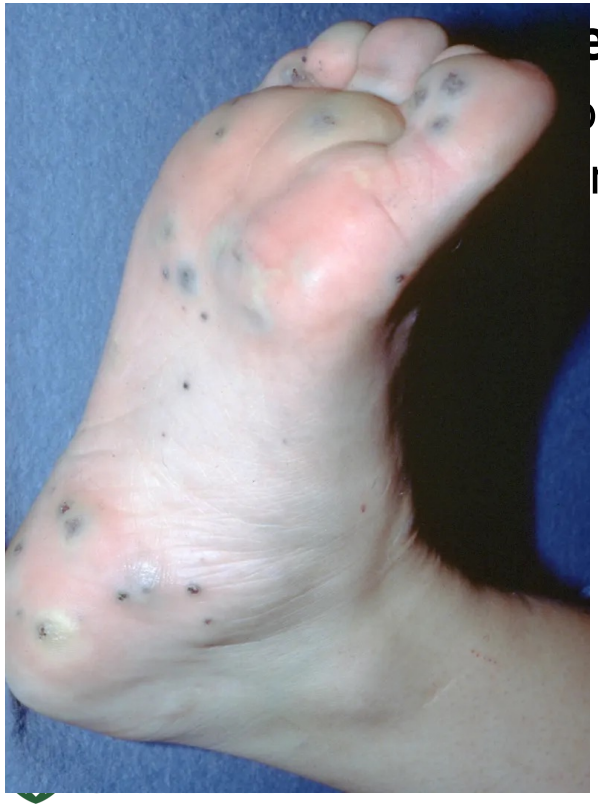
Case 9



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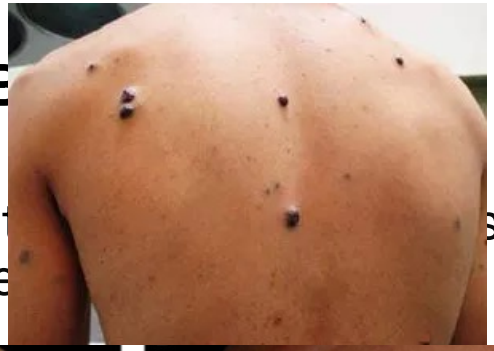
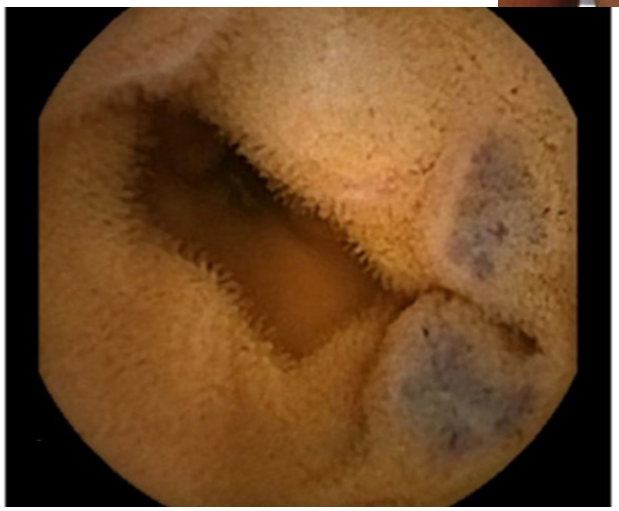
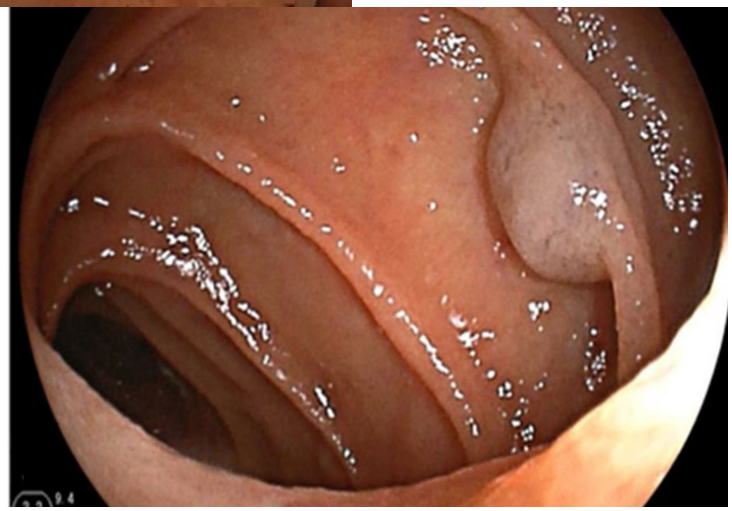
nd GI venous malformat soft, polyp-

cause bleeding and ane







Case 9

- **Blue Rubber Bleb Nevus Syndrome (BRBNS)**
  - Rare congenital disorder
  - Diffuse cutaneous and GI venous malformations, revealing blue, soft, polyp-like lesions that can cause bleeding and anemia
  - Often initially dx with colonoscopy, but ensure VCE of the small bowel as it very commonly affects the small bowel as well
  - Diagnostic imaging (MRI or CT) to rule out other serious venous malformation

Case 9

- **BRBNS**
  - Rx of GI venous malformation depends on if the patient is symptomatic
    - If active bleeding - electrocautery, endoscopic clipping or banding has been demonstrated to be effective Rx
    - Supportive care with iron replacement, blood transfusion in acute bleeds
  - Consider a multidisciplinary approach with dermatology and IR if cutaneous or serious non-GI venous malformations present

Summary

- Many interesting endoscopic findings that are not polyps or cancer!
- Recognition of uncommon endoscopic findings can assist in further choice of diagnostics test, treatments and affect patient outcomes
- Provincial EMR makes it easy to get a second opinion so….
- TAKE LOTS OF PICTURES
  - Up close, far away, different imaging modalities

Questions?

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