



Case Report

New Presentation of Inlet Patch with Polypoid Kissing Pattern: Case Report

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Abstract

In the worldwide medical literature, only one case of inlet patch shows a kissing pattern on endoscopy. This article describes a 69-year-old female patient who came to the gastroenterology clinic, Rohani hospital, Babol University of Medical Sciences (Iran) for an examination for indigestion. Endoscopy showed two polyps in the background of a maroon patch just below the upper esophageal sphincter, oppositely positioned in view of the kissing pattern, and extending into muscular mucosa and regional lymph nodes. There was no A polyp biopsy was performed and, on histological evaluation, there was heterotopic cardiac gastric mucosa. Since heterotopic gastric mucosa can be found anywhere in the gastrointestinal tract, careful examination of the proximal esophagus increases the likelihood of detecting an inlet patch.

Keywords: Intestinal polyps, Case reports, Heterotopic tissue

Cite this article as: Nikbakhsh K, Mojaddad A, Shokri Shirvani J, Ranaee M. New presentation of inlet patch with polypoid kissing pattern: Case report. *Middle East J Dig Dis* 2023;15(1):66-67. doi: 10.34172/mejdd.2023.324.

Received: July 12, 2022, Accepted: December 10, 2022, ePublished: January 30, 2023

Introduction

Heterotopic gastric mucosa can be seen anywhere in the gastrointestinal tract, gallbladder, and liver. The most common site in the gastrointestinal tract is the proximal esophagus, known as the inlet patch. Lesions below the upper esophageal sphincter may be missed on endoscopic examination. They are either patchy or circular and polyps are rarely seen. Although often asymptomatic the inlet patch can also manifest clinically with spasm, web, esophagitis, ulceration, bleeding, or extraesophageal fistula due to acid secretion from the gastric mucosa.¹ It can sometimes show malignant progression in the sequence of metaplasia-dysplasia-adenocarcinoma as in other parts of the gastrointestinal tract.²

Our study aims to present a new case of inlet patch with clinicopathological findings.

Case Report

A 69-year-old woman with diabetes mellitus was referred to the gastroenterology clinic, Rohani hospital, Babol University of Medical Sciences (Iran) for evaluation due to dyspepsia. She has heartburn and a globus sensation. Examination of the oral cavity and neck was normal. Laboratory findings were unremarkable without past medical history. At the below of the upper esophageal sphincter about 17 cm from a bite guard in upper endoscopy observed two polyps (8×7 mm) in the background of maroon-colored patches (Figure 1). Polyps were located in positions opposite to the kiss pattern.

Polyps originated from the mucosa without extension to muscularis mucosa and no regional lymph nodes were seen at endoscopic upper sonography. Biopsy of this patch showed a heterotopic cardiac gastric mucosa in the upper esophagus (Figure 2). This case may be a good candidate for endoscopic therapy with argon plasma coagulation (APC) or radiofrequency ablation. However, the patient did not accept the proposed endoscopic treatment. So we suggested proton pump inhibitors and changed his diet.

Discussion

Inlet patches appear as velvety, salmon-colored mucosa, usually in the cervical esophagus.³ The size and shape can vary, being flat, depressed, or elevated. The incidence is reported as 0.1%-10% of adults.^{3,4} This can be primarily influenced by a careful examination of the upper esophagus by the endoscopist. Because the clinical relevance of cervical inlet patches has not been widely recognized, the upper esophagus has been intubated by the endoscopist without careful inspection and then often quickly passed when withdrawing the endoscope.⁵ Cervical inlet patches are often asymptomatic, but several symptoms were reported to be associated with inlet patches: chronic cough, sore throat, globus sensation, dysphagia, and odynophagia. Inlet patches may lead to some complications, including esophageal strictures, rings or webs, obstruction, food impaction, adenocarcinoma, bleeding, ulceration, perforation, tracheoesophageal fistulas, and vocal cord dysfunction. These complications



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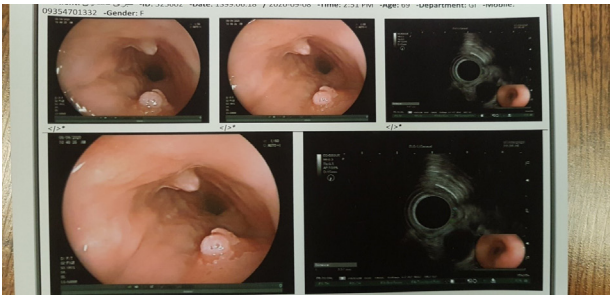


Figure 1. Endoscopic image of heterotopic gastric mucosa of the proximal esophagus and its kissing pattern

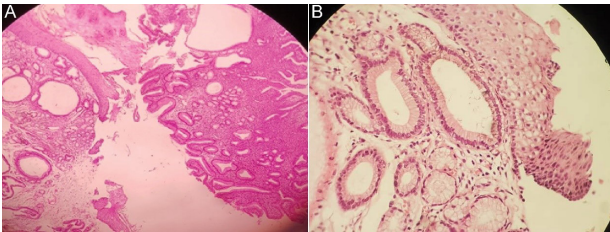


Figure 2. histopathology of the inlet patch showing gastric mucosa and normal esophageal mucosa. (Low power field (A), high power field (B))

are hypothesized to result from acid production by parietal cells in the ectopic mucosa.⁶ Our patient had two unique endoscopic presentations: Polypoid kissing pattern and remnant squamous mucosa on polyps in the background of gastric-type patches. The histological study showed no *H Pylori* infection in gastric heterotopia. There was no metaplasia or dysplasia.

Conclusion

Heterotopic gastric mucosa can be seen anywhere in the gastrointestinal tract, and careful examination of the

proximal esophagus may increase the chance of detecting an inlet patch. This may explain persistent symptoms in patients without a specific cause. Our patient had a polypoid kiss pattern from the inlet patch. Further studies are needed to determine the most appropriate treatment for these patients.

Acknowledgements

The authors would like to express gratitude to the Clinical Research Development Unit of Rouhani Hospital in Babol, Iran.

Competing Interests

The authors declare no conflict of interest related to this work.

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