EDITOR’S QUIZ: GI SNAPSHOT

Unusual cause of a giant antral ulcer

CLINICAL PRESENTATION
A 31-year-old man visited our gastroenterology clinic owing to continuous epigastric pain lasting 3 months, diarrhoea during the previous month and an associated 10 kg weight loss. An ulcer in his antrum was discovered by oesophagastroduodenoscopy (EGD), and he took a proton-pump inhibitor for a month. However, his clinical symptoms and ulcer worsened. He denied melena, haematemeses, fever, arthralgia, recurrent aphthous ulcer and genital ulcer. He had a >10-year history of asthma and eczema. Physical examination was unremarkable except for emaciation and upper abdominal tenderness. Laboratory test results were normal, including routine stool studies, serum amylase measurement, liver function tests, tumour marker measurements, 14C-urea breath test and parasite tests. A remarkable EGD finding was a giant ulcer in the antrum (figure 1A). Colonoscopy showed multiple shallow ulcers (0.2–0.4 cm) throughout the colon (figure 1B). Contrast-enhanced CT showed a markedly thickened gallbladder wall, with a non-enhancing hypodense area around the portal vein (figure 2).

QUESTION
What is the diagnosis?

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Figure 1  Endoscopic view of the stomach (A) and colon (B).

Figure 2  CT of the abdomen.
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ANSWER

White cell and eosinophil counts were 22,690/mm³ and 59.7%, respectively. Histological examination of gastric antrum (figure 3A) and random colon biopsies (figure 3B) revealed heavy eosinophilic infiltration. Oral prednisone (30 mg qd) was started. The patient’s epigastric pain and diarrhoea resolved and eosinophil count normalised rapidly. A month later, imaging studies revealed antral and colonic ulcer healing, a normal gall-bladder wall and disappearance of the low-density area around the portal vein. Treatment was stopped after 6 months, and the patient was doing well. Eosinophilic gastroenteritis (EG) was finally diagnosed.

EG is a rare disease characterised by eosinophilic infiltration of the GI tract, with reports of cholangitis-associated EG. Allergic response may play a central role. Diagnostic criteria include recurrent GI symptoms, predominant eosinophilic infiltration (eosinophil sheets on histopathology) and no parasitic or extraintestinal disease.1,2 Idiopathic hypereosinophilic syndrome, a heterogeneous collection of disorders marked by hypereosinophilia and organ damage, is a differential diagnosis,3 but was ruled out because our patient had a history of asthma and eczema and no organ involvement except for the digestive system.

To our knowledge, this is the first reported case of EG presenting with a giant gastric ulcer, colonic ulcer, cholecystitis and portal area inflammation.

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