Rare Gastric Cardia Polyp Causing Complete Esophageal Obstruction

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ABSTRACT

A 67-year-old man presented with food impaction and was found to have a gastric polyp obstructing the esophageal outlet. Due to the polyp’s location and size, no immediate endoscopic intervention was performed, and the patient returned for intraoperative endoscopy and polypectomy. Cases of gastric polyps causing esophageal obstruction have not been identified in the literature. This case is unique for the location and size of the polyp, necessitating concomitant surgical management.

INTRODUCTION

Food bolus impaction is a common indication for emergent endoscopy. Impaction most commonly occurs secondary to structural or physiologic pathology in the esophagus. Upper gastrointestinal tract polyps are rare and, when identified, are usually an incidental finding and are asymptomatic. To our knowledge, a gastric polyp causing esophageal obstruction has not been reported in the literature.

CASE REPORT

A 67-year-old white man presented with difficulty swallowing. He reported consuming pork 12 h prior, and felt it lodged in the area of his lower sternum. He denied weight loss, heart burn, hematemesis, odynophagia, previous impaction, or prior endoscopic evaluation for dysphagia. His medical history was remarkable for non-insulin-dependent diabetes mellitus, hypertension, hyperlipidemia, and gout; his surgical history was unremarkable. His medications included daily low-dose aspirin, atenolol, metformin, and allopurinol. Vital signs were within normal limits. Physical exam was remarkable only for significant sialorrhea. Initial laboratory tests were unremarkable, including hemoglobin 16.2 g/dL and hematocrit 45.9%.

Urgent endoscopy revealed a severe food impaction involving more than two-thirds of the esophagus. The hypopharynx and esophagus did not reveal a diverticulum, ring, stricture, or an underlying mass. As the food bolus was moved into the body of the stomach, a gastric polyp partially obstructing the esophageal outlet was observed (Figure 1). Further exploration revealed a large gastric polyp, best visualized on retroflexion, partially obstructing the esophageal outlet (Figure 2). Due to the polyp’s location, the polyp was inaccessible for resection or hemostasis despite maximal retroflexion, so no immediate endoscopic intervention was performed.

The patient returned 3 weeks later for an intraoperative endoscopy with polypectomy. During the endoscopy, a surgical trochar was placed into the greater curvature of the stomach and a therapeutic scope was advanced through the trochar. A single frond-like, villous, pedunculated polyp, measuring more than 20 mm, was directly visualized with the endoscope through the surgical trochar (Figure 3). The polyp was removed using a hot snare and retrieved from the cardia through the surgical trochar. Pathology subsequently revealed a hyperplastic gastric...
polyp. The patient was discharged home with resolution of dysphagia. The patient returned to clinic for follow-up and reported no further episodes of dysphagia or food impaction. No further testing was pursued, as the cause of dysphagia was attributed to the obstructing gastric polyp.

DISCUSSION

Food bolus impaction in adults most commonly occurs due to existing structural or physiologic pathology in the esophagus. Underlying conditions include diverticula, rings, strictures, carcinoma, hiatal hernia, eosinophilic esophagitis, and achalasia.

Upper gastrointestinal tract polyps are rare and are most commonly discovered incidentally during endoscopy.¹ The majority of these polyps arise from the gastric body and antrum; the proportion of polyps in the gastric cardia is less and has remained relatively static.² These polyps are usually asymptomatic; if present, clinical symptoms may be related to occult bleeding and anemia. Cardiac polyps are usually benign, are usually less than 1 cm, and are not associated with esophagitis, Barrett’s esophagus, gastroesophageal reflux, or gastritis.³ Cases of large polyps causing intermittent pyloric obstruction, with the resultant symptoms, have been reported.¹ However, similar cases of gastric polyps leading to esophageal obstruction have not been identified in the literature.

Polypectomy is indicated in this case due to both the symptomatic nature and the risk of malignant transformation. This case is unique for the location and the size of the polyp, rendering it inaccessible to traditional endoscopic removal. Concomitant surgical management in the operating room, under direct visualization, was required for patient safety and the optimal result of a successful polypectomy.

DISCLOSURES

Author contributions: All authors contributed equally to the manuscript. K. Leroy is the article guarantor.

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