

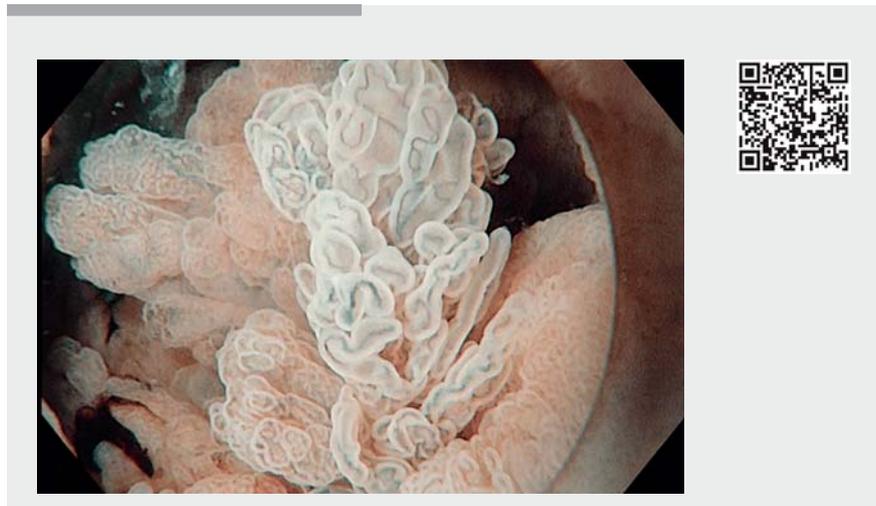
Giant atypical hyperplastic lesions on Barrett's esophagus and at the esophagogastric junction resected by endoscopic submucosal dissection

Barrett's esophagus (BE) neoplasms are usually flat or slightly depressed and should be treated by endoscopic resection when lesions are visible, according to European Society of Gastrointestinal Endoscopy (ESGE) guidelines [1].

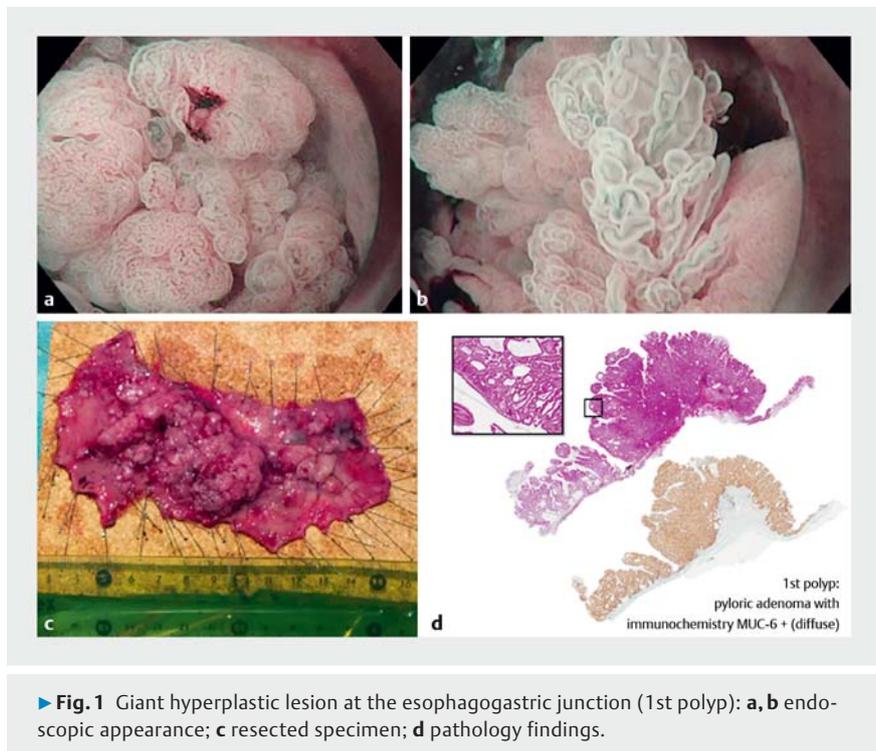
We report here an unusual case of several villous semipedunculated [2] lesions all located along a C10M10 BE and at the esophagogastric junction (EGJ) (► **Video 1**).

Macroscopically, the largest lesion (► **Fig. 1**) was an exophytic villous polyp with abundant mucus secretion that had developed on the EGJ. There was no depressed area and the pit pattern was type IV regular pattern [3]. Previous biopsy samples showed low grade dysplasia, and computed tomography (CT) scan and endoscopic ultrasound (EUS) evaluation did not reveal lymph node metastasis or muscle invasion.

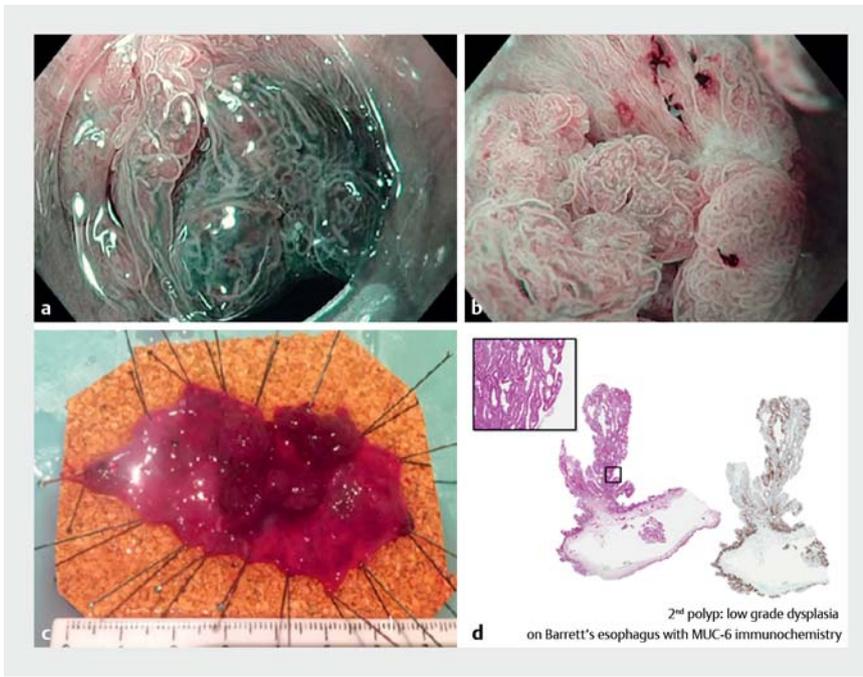
Endoscopic submucosal dissection (ESD) was proposed and achieved en bloc R0 resection of a 14×6-cm specimen. After expert pathology discussion, the final diagnosis was hyperplastic foveolar polyp of size 10×5 cm that had developed upon a cardiac mucosa, with no sign of intestinal metaplasia nor of dysplasia. Complementary examinations were carried out, and revealed diffuse marking of the lesion with anti-MUC6 antibodies, pointing to pyloric adenoma. However, pyloric adenomas usually present *RAS* or *GNAS* mutations but none of these could be identified. Follow-up endoscopy did not show any recurrence at the ESD site. The second largest lesion was located in the middle of the BE and had a similar pedunculated hyperplastic aspect. A second ESD procedure was performed (► **Fig. 2**) without adverse events, allowing an en bloc R0 resection of a 7×5-cm area. Pathological examination revealed low grade dysplasia on BE mucosa.



► **Video 1** Endoscopic appearance of giant hyperplastic lesions at the esophagogastric junction and at the middle part of Barrett's esophagus area.



► **Fig. 1** Giant hyperplastic lesion at the esophagogastric junction (1st polyp): **a, b** endoscopic appearance; **c** resected specimen; **d** pathology findings.



► **Fig. 2** The low grade dysplasia lesion on the Barrett's esophagus (2nd polyp): **a, b** endoscopic appearance; **c** resected specimen; **d** pathology findings.

This combination of different lesions with both a hyperplastic lesion of the EGJ and pedunculated low grade dysplasia is not usual, especially considering the large size of the lesions [4]. Aggravated mucosal injury due to gastroesophageal reflux disease could be responsible. ESD is an option for removing those large lesions en bloc and with margins.

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Competing interests

None

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