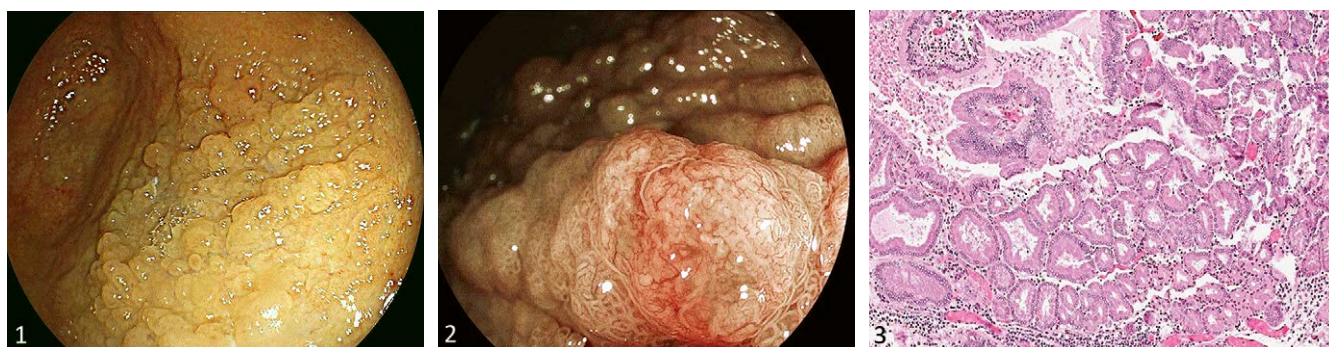


An Uncommon Type of Gastric Adenoma: Pyloric Gland Adenoma with Foveolar Dysplasia

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An 80-year-old woman presented with *de novo* epigastric pain and heartburn. The patient underwent an upper endoscopy which demonstrated a 35 mm superficial elevated lesion (Paris 0-IIa) located in the cardia and upper gastric body (Figs. 1 and 2). With blue-laser imaging an irregularity of microvascular pattern within the lesion was detected (Fig. 2). Biopsy specimens revealed an adenoma with high-grade dysplasia. En-bloc endoscopic submucosal dissection was performed without adverse events. Histopathology showed small, closely disposed glands lined by cuboidal or low columnar cells, with round-to-ovoid basal nuclei (Fig. 3). Foveolar-type dysplasia was also observed focally, with tubulovillous structures lined by columnar cells with basal nuclei and the presence of apical neutral mucin, with free margins (R0). Immunohistochemistry was positive for mucin (MUC)6 and MUC5AC and negative for CDX2, CD10 and p53. A diagnosis of gastric pyloric gland adenoma (PGA) associated with foveolar-type dysplasia, was made.

Pyloric gland adenomas account for <3% of all gastric polyps and are precancerous lesions presenting a high probability of change into gastric adenocarcinoma [1]. They are more common in women in the 7th decade, located in the upper body and fundus; pseudopyloric metaplasia is thought to be the precursor lesion of PGA [2, 3]. Pyloric gland adenomas were described as a distinct entity from gastric foveolar type adenoma (GFTA) with the main discriminating feature being the absence of mucin cap and co-expression of MUC5AC and MUC6 in PGA (while in GFTA there is a characteristic mucin cap and expression of MUC5AC but absence of MUC6) [4]. Furthermore, the presence of high-grade dysplasia and progression to adenocarcinoma is more frequent in PGAs [4, 5]. Here we present the endoscopic and pathological

iconography of an uncommon variant of gastric adenoma, highlighting that not all gastric adenomas are equal; PGAs have distinct histological features and a higher risk of progression.

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Conflicts of interest: None to declare.

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