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Collagenous Gastritis Observed by Magnifying Narrow-Band Imaging Endoscopy

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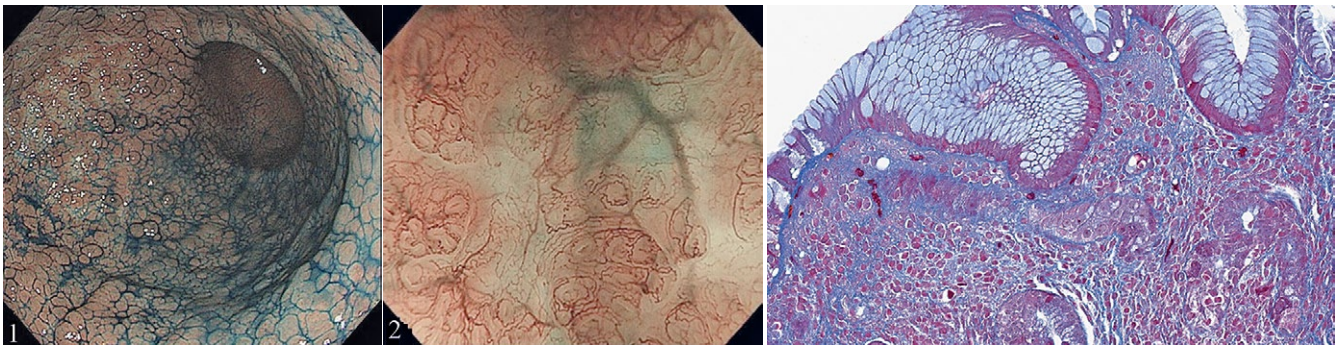

A 42-year-old woman with a 7-year history of Sjögren syndrome underwent upper gastrointestinal barium radiography for gastric cancer screening. Double-contrast radiography disclosed nodular, flat-topped lesions diffusely distributed in the upper and middle thirds of the stomach. Esophagogastroduodenoscopy (EGD) with indigo-carmine dye showed multiple flatly elevated lesions (Fig. 1). Magnifying endoscopy with narrow-band imaging (M-NBI) revealed tubular structures on the surface of the nodules and areas of non-structure accompanied by thin and tortuous vessels in the intervening mucosa (Fig. 2). Histological examination of multiple biopsy specimens revealed infiltration with inflammatory cells in lamina propria and severely atrophied epithelium. Azan staining (200x) revealed markedly thickened subepithelial collagen bands (Fig. 3). Specimens obtained from the nodules showed mild inflammation without thickening in the subepithelial collagen band. Histology, serology and urea breath test were negative for *Helicobacter pylori* infection. Further investigations including capsule endoscopy and colonoscopy with biopsies did not show any sign of collagenous sprue or collagenous colitis. We diagnosed this case as collagenous gastritis (CG).

Endoscopic findings in CG have been characterized by fine and fading nodularity surrounded by slightly depressed, atrophic mucosa [1]. Pathologically, dense collagen depositions are found in the intervening, atrophied mucosa, whereas the nodules contain mild inflammatory infiltrates without thickened collagen bands [1, 2]. However, little has been reported on the M-NBI findings of CG to date. Kawamura et al. [3] reported that a tubular gastric micromucosal pattern under M-NBI is representative of infiltration of inflammatory cells and degeneration of the surface epithelium, while an obscure surface structure with irregular, narrowed, and coiled subepithelial capillaries is compatible with moderate to severe mucosal atrophy and intestinal metaplasia. Our case suggests that the co-existence of these two distinctive M-NBI findings may be diagnostic of CG.

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Conflicts of interest: None to declare.

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