Dear Editor,

We present the case of a 69-year-old female undergoing esophagogastroduodenoscopy for iron-deficiency anemia investigation. She reported intermittent bloating, nausea and vomiting. A pedunculated polyp was identified arising from the greater curvature of the middle gastric body, with a long fibroelastic stalk (30 mm) and a 60-mm congestive head that prolapsed towards the pyloric ring, causing a complete gastric outlet obstruction (GOO). An en-bloc polypectomy was performed and an intraprocedural oozing bleeding from a large visible vessel at the residual stalk was managed using Endoloop®. Immunohistochemistry showed a R0-resection of a mixed-type gastric pyloric gland adenoma (PGA) positive for MUC-5AC.
and MUC-6 mucins, in a surrounding *H. pylori*-negative, non-atrophic chronic gastritis. The patient became asymptomatic with anemia resolution.

Adenomas account for up to 10% of gastric polyps. Histologically, they are categorized into intestinal, foveolar, pyloric, and oxyntic types (1). PGA is a rare subtype, accounting for less than 3% of all gastric polyps (2). PGAs are usually solitary at the gastric body, and occur in association with autoimmune gastritis, *H. pylori*, and chemical gastritis (2). A normal background gastric mucosa has also been described (35.8%) (3).

PGAs are devoid of apical mucin cap and label with both MUC-5AC and MUC-6 (2). Choi et al. (3) defined three immunohistochemical phenotypes for PGA: pure pyloric type (25.4%) with strong MUC-6 expression; predominant foveolar type (3%) with MUC-5AC diffuse expression but ≤ 10% of MUC-6 expression and no foveolar differentiation; and mixed type (61.2%) with variable MUC-5AC/MUC-6 expression.

Most PGAs are asymptomatic, but clinically significant because of their potential for malignant transformation (12-47%) and complications, including gastrointestinal bleeding and obstruction (1,3). GOO is rare, causing intermittent symptoms by polyp intussusception (ball-valve syndrome) (4,5).

PGA management is challenging, depending on the lesion’s size, morphology, and location. This case illustrates a successful endoscopic resection as a minimally invasive procedure of a doubly complicated PGA.

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REFERENCES


Fig. 1. A. Endoscopic view of the long and fibroelastic stalk of the polyp arising from the greater curvature of the middle gastric body. B. Endoscopic view of the pedunculated polyp with a congestive head prolapsed towards the pyloric ring, causing complete gastric outlet obstruction. C. Successful management of the oozing bleeding from a large visible vessel at the residual stalk with an Endoloop® (lower right corner, polypectomy specimen). D. Histology revealed a gastric pyloric gland adenoma composed of closely packed pyloric glands lined by cuboidal/columnar epithelial cells with eosinophilic cytoplasm and basal nuclei with inconspicuous nucleoli, alternating with areas of glandular dilation (hematoxylin-eosin, 20x magnification). E. Immunohistochemical staining positive for MUC-5AC (20x magnification). F. Immunohistochemical staining positive for MUC-6 (40x magnification).