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Pedunculated mucosa-associated lymphoid tissue (MALT) lymphoma causing gastric outlet obstruction

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An 86-year-old female presented with anemia and dyspepsia. She underwent esophagogastroduodenoscopy that revealed a giant pedunculated polyp located in the gastric corpus protruding into the duodenal bulb, causing gastric outlet obstruction (GOO) **(Fig. 1)**. Endoscopic resection was scheduled.

Submucosal injection and loop placement were performed. Standard polypectomy with a 30 mm snare was impossible due to the fibrotic nature of the polyp. Direct dissection of the stalk was tried, but visualization of the cutting plane was poor so the resection was cancelled. Biopsies were taken, showing non-specific chronic inflammation.

A second endoscopy was scheduled 4 weeks later due to persistence of symptoms. The polyp still protruded through the pylorus, but it had markedly shrunk **(Fig. 2).** Standard polypectomy was performed. The histological evaluation confirmed the atypical presentation of a pedunculated low-grade MALT-lymphoma with immunohistochemical stain CD20 (+) in the submucosa under a normal gastric mucosa **(Fig. 3)**. Extra-gastric disease was excluded. *H. pylori* eradication was indicated. GOO symptoms disappeared with no adverse effects.

The main cause of GOO are malignant neoplasms (50-80%). Symptoms include nausea, vomiting or dyspepsia (1). Many different endoscopic presentations have been reported for MALT-lymphoma. While erosive or ulcerated lesions are the most common findings, presentation as a giant pedunculated mass is extremely rare (2). Other possible obstructing condition associated with MALT-lymphoma, such a pseudotumor lymphomatous polyposis had also been described (3). Histologic diagnosis can be difficult using biopsy alone because of its submucosal growth. In our case, endoscopic resection allowed both diagnosis and symptomatic resolution.

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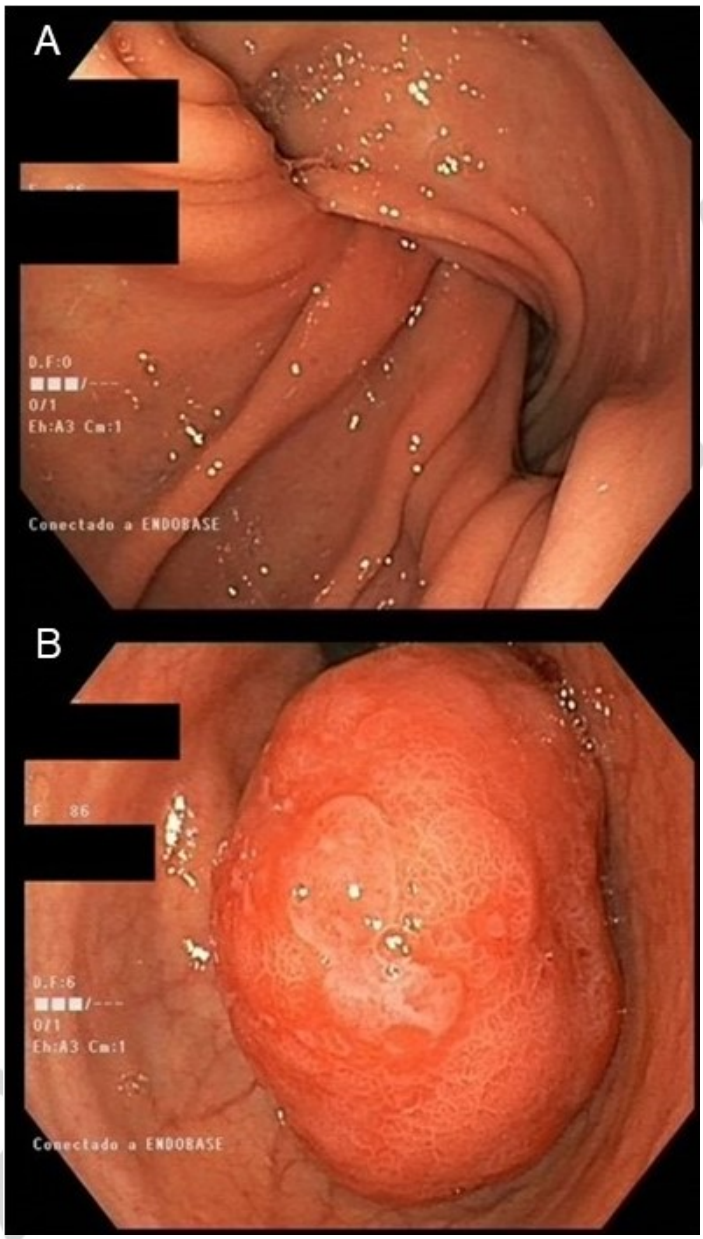

Fig.1. A. Esophagogastroduodenoscopy showed a giant pedunculated polyp with a 25 mm stalk protruded into the duodenal bulb causing GOO. B. A 35 mm polyp head

visualized using retroflexion in the duodenum.

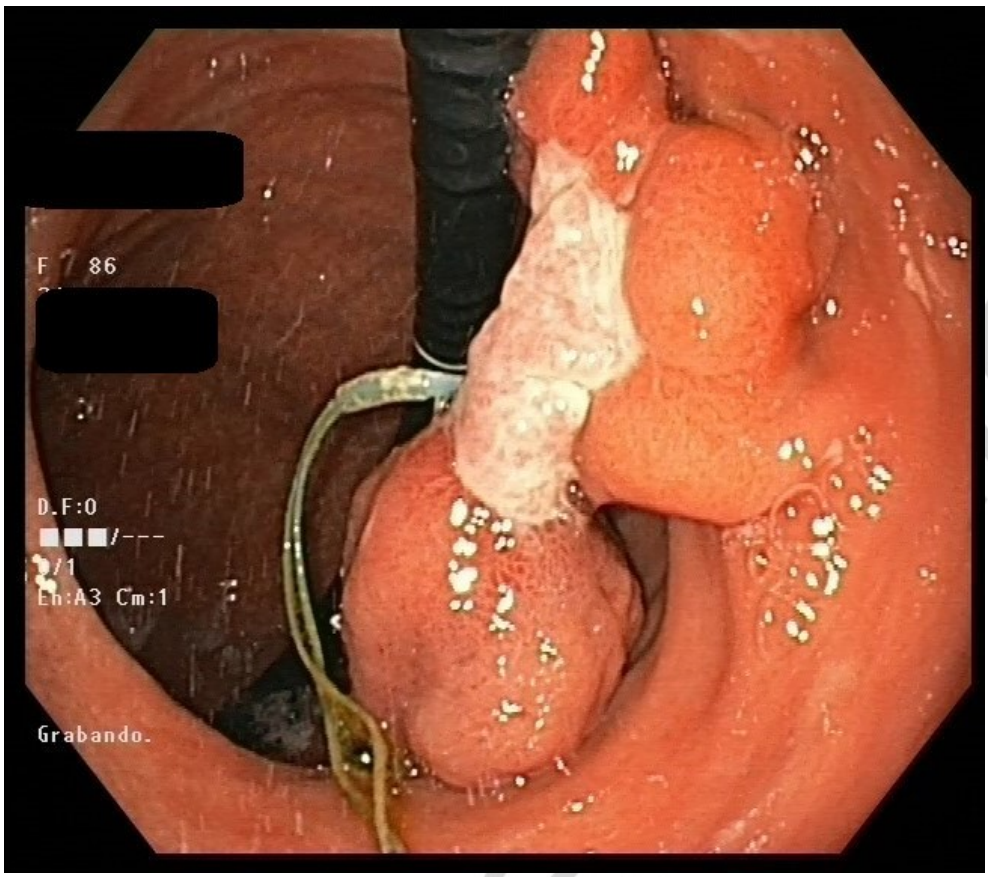

Fig. 2. The second esophagogastroduodenoscopy showed an ulcerated polyp stalk containing fibrin on its surface and a marked decrease in polyp size.

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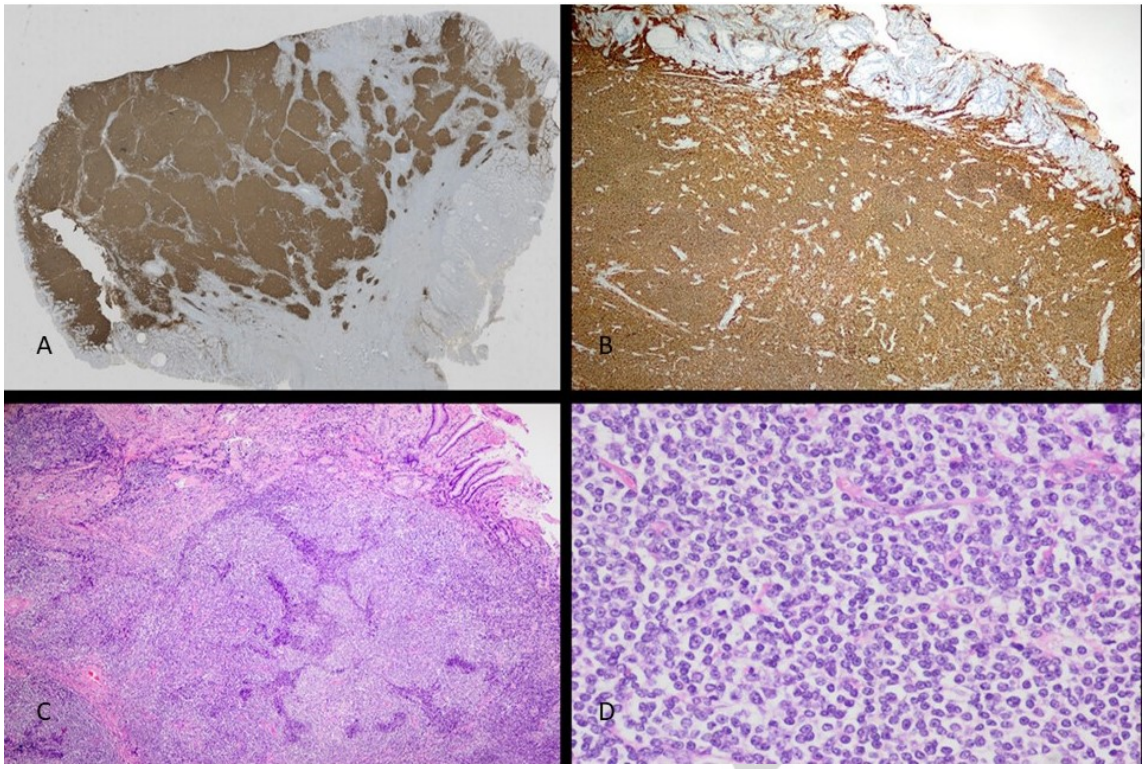

Fig. 3: A. CD20+ immunohistochemical analysis, polyp stalk free of lymphoma infiltration, B. CD20+ lymphoid cellularity with normal antral mucosa on the surface. C. Haematoxylin-eosin stain with well-differentiated lymphoid cellularity. D. Haematoxylin-eosin stain. Higher magnification.