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Gastric calcinosis ulcer in a renal transplanted patient

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Dear Editor,

A 53-year-old female with dysfunctional renal transplant and post-surgical hypoparathyroidism with phosphocalcic metabolism impairment was admitted to hospital because of long-lasting epigastric pain and nausea. An esophagogastroduodenoscopy was performed, finding a nodular lesion of 1 cm in diameter with a depressed and ulcerated base (Fig. 1). Microscopically, the lesion was related with a metastatic calcinosis ulcer (Fig. 2). Pantoprazole was initiated and serum phosphocalcic levels adjusted, achieving symptom remission. In the follow-up esophagogastroduodenoscopy, the lesion was healing with a fibrinous base (Fig. 3) and the histopathological report reported a diagnosis of superficial gastritis.

Discussion

Calcinosis can be classified as metastatic, dystrophic, iatrogenic or idiopathic. Usually it affects the dermis, subcutaneous tissue and small-caliber vessels, although it may appear in

the lungs, heart or abdominal organs. The most frequent gastrointestinal calcinosis is the metastatic form (1). It is common in patients with phosphocalcic metabolism impairment, chronic kidney disease or in transplanted patients (2).

Despite the scarcity of literature, the adjustment of calcium and phosphorus levels is part of the treatment. Refractory cases to basic treatment could require endoscopic or surgical treatment. Given the potential fatality of the disease, the prevention of these complications in high-risk patients must be among the main therapeutic goals (1,3).

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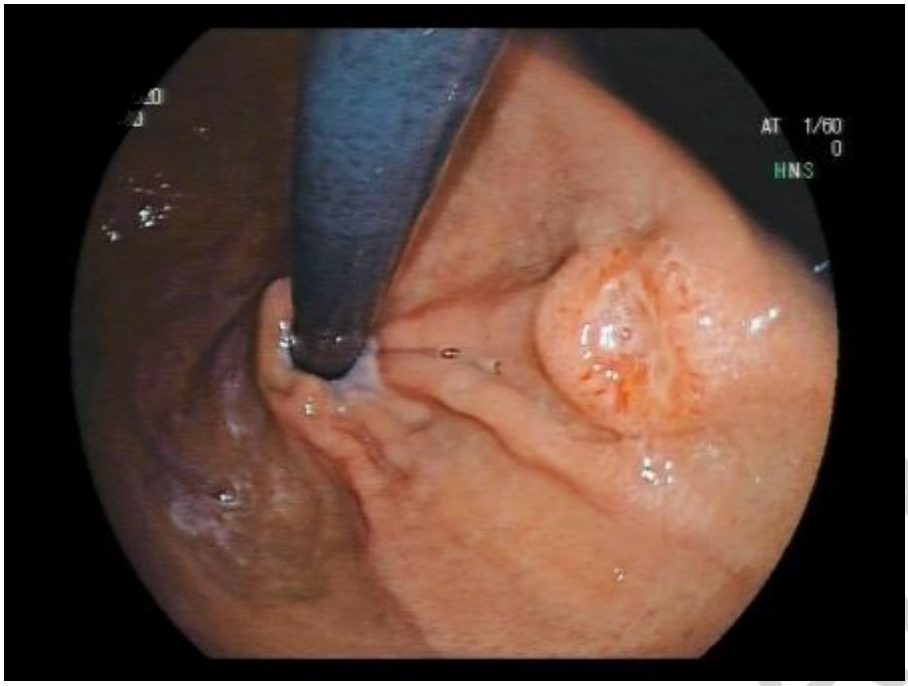

Fig. 1. Ulcerated lesion with irregular borders, tortuous and aberrant vessels in the periphery and elastic consistency on sampling. Lesser gastric curvature.

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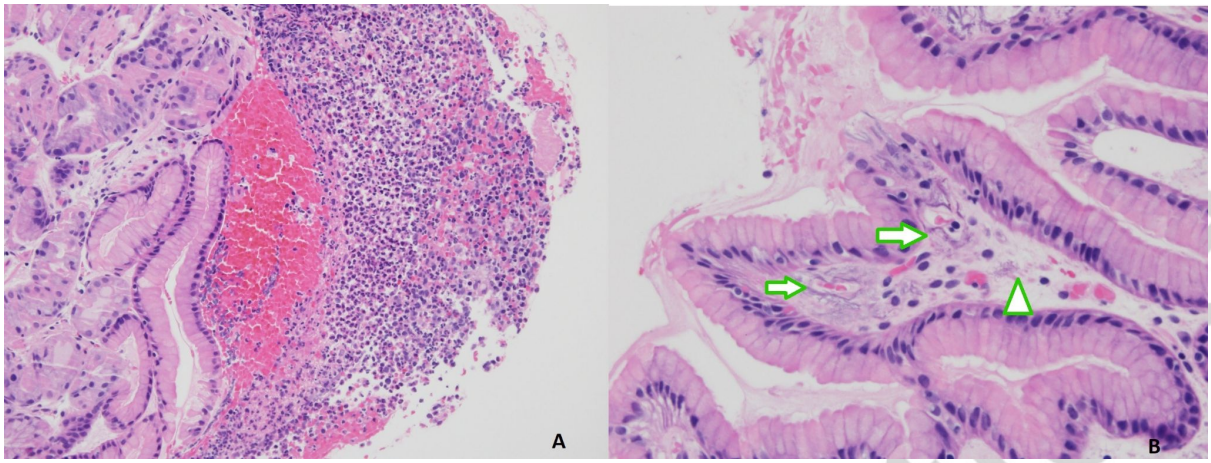

Fig. 2. Hematoxylin-eosin. A. Gastric mucosa with a superficial ulcerated area, substituted by inflammatory cells and fibrin (200x magnification). B. Stromal (arrowhead) and small vessel wall (arrows) deposits of metastatic calcification (x400 magnification).

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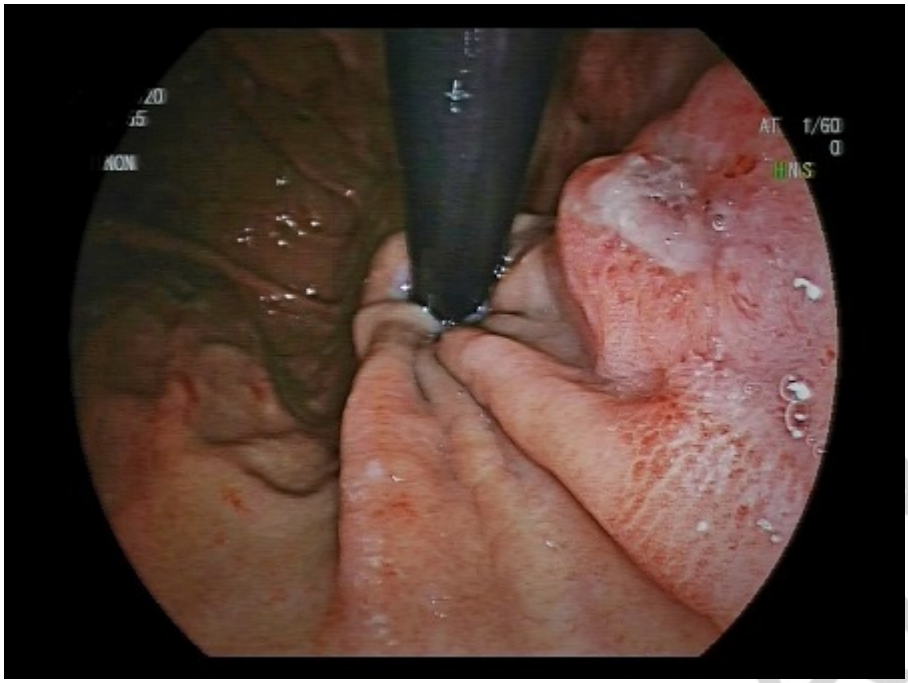

Fig. 3. Re-epithelialization of the bottom of the ulcer. Adjacent mucosa with erythematous-inflammatory changes.