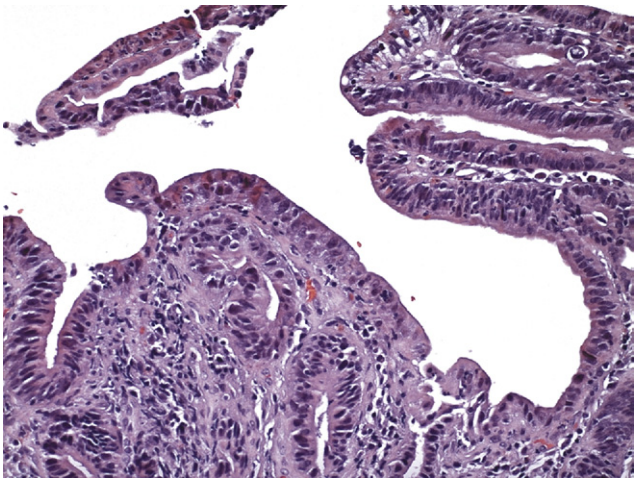

Figure 3. Low-grade to focally high-grade dysplasia at a Crohn's stricture.

pathology confirmed high-grade dysplasia but no invasive cancer in the resected specimen (Fig. 3).

DISCUSSION

The association of Crohn's disease with small-bowel carcinoma is uncommon but represents a real risk for patients with long-standing disease.[5] There are few reports investigating this phenomenon, and lack of endoscopic access to the small bowel further impairs study. We present a novel approach in surveying small-bowel Crohn's disease.

Assessment of carcinoma or dysplasia in a patient with long-standing small-bowel Crohn's disease is problematic. However, deep enteroscopy allows for direct visualization and sampling of small-bowel mucosa as well as controlled dilation of short strictures. The technique using double-balloon and single-balloon systems has been described.[6-7] To our knowledge, this is the first report of using a spiral overtube for this purpose. We have used this technique to achieve insertion depths of up to 100 cm proximal to the ileocecal valve by using our existing pediatric endoscopes and disposable overtubes. This technique may prove to be a reliable method for surveying ileal involvement in patients with long-standing Crohn's disease.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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Multiple portal hypertensive polyps of the jejunum accompanied by anemia of unknown origin

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A 58-year-old man with alcoholic liver cirrhosis, diabetes mellitus, and chronic renal failure was admitted after reporting general fatigue, which was found to be caused by worsening anemia. Upper GI endoscopy revealed grade 1 esophageal varices without red spots and mild telangiectasia in the gastric antrum without the typical portal hypertensive gastropathy. Colonoscopy revealed rounded and swollen villi, known as a herring roe appear-

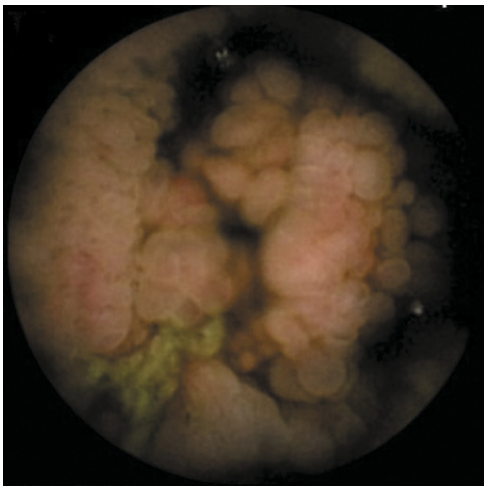

Figure 1. Capsule endoscopy showing multiple elevated lesions in the jejunum.

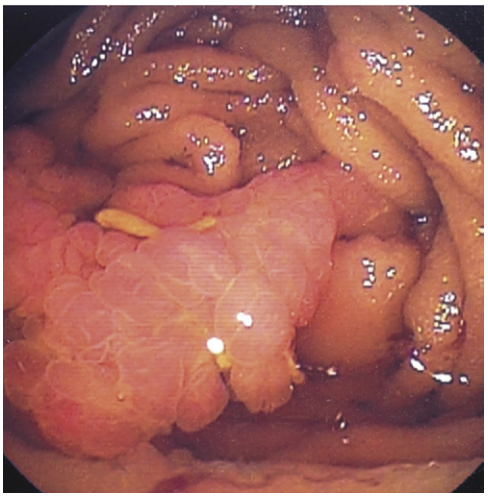

Figure 2. Balloon-assisted enteroscopy showing multiple elevated lesions with nodular surfaces in the upper jejunum.

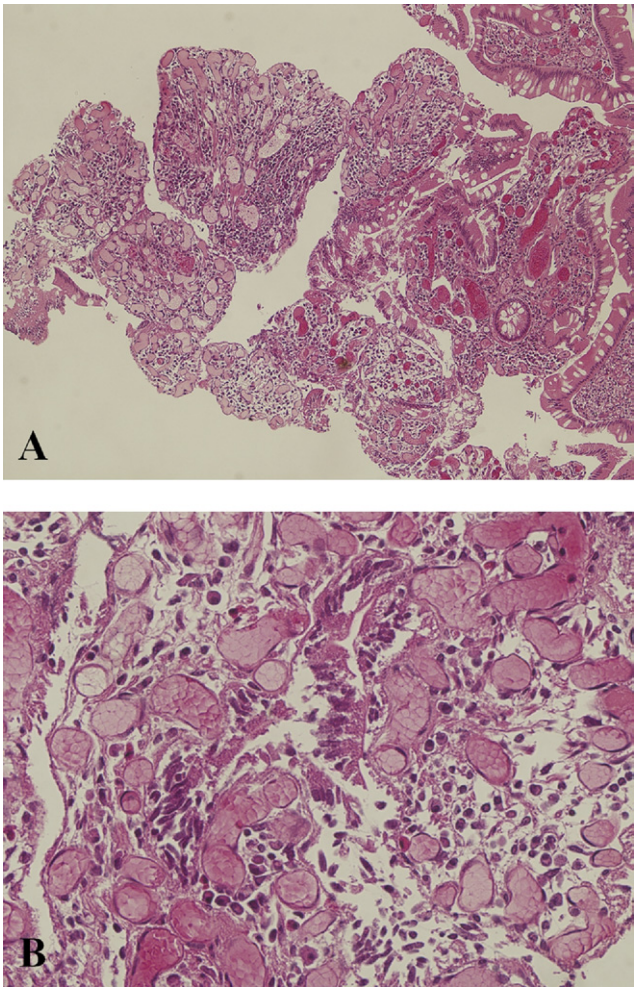

Figure 3. The histological findings of the polypectomy specimen showing numerous areas of capillary dilation in addition to the proliferation and congestion in the lamina propria. No dysplastic changes were detected. **A**, H&E, orig. mag. ×100. **B**, H&E, orig. mag. ×400.

ance, in the terminal ileum.[1] The patient had microcytic and hypochromic anemia with low serum ferritin. In addition, the fecal occult blood test result was positive and the serum erythropoietin level was elevated (41.7 mIU/mL) (normal 8-36 mIU/mL). Iron deficiency was believed to be the main cause of the anemia. Conventional upper GI endoscopy and colonoscopy revealed no GI bleeding. Because the origin of the bleeding site was obscured, we performed a capsule endoscopy (CE), which detected multiple elevated lesions with nodular surfaces and cherry red spots in the upper jejunum (Fig. 1). By using oral balloon-assisted enteroscopy (BAE), we found raised lesions of various sizes with nodular surfaces, which were difficult to distinguish from a villous adenoma or hyperplasia on superficial examination (Fig. 2). One of the lesions was removed by snare polypectomy for histological analysis. The histological findings showed capillary dilation, proliferation, and congestion in the lamina propria. There were no cytological or nuclear atypia for the mucosal glands or proliferating vessels (Fig. 3). Despite the unusual presentation, these pathological changes were consistent with those of portal hypertensive enteropathy. Thus, our diagnosis of portal hypertensive polyps (PHPs) in the jejunum was ultimately found to be correct. Because the PHPs were assumed to be the cause of the anemia, although there was no active hemorrhage from the PHPs, an iron supplement was prescribed. The patient showed gradual recovery from anemia with this treatment.

Esophagogastric and rectal varices, portal hypertensive gastropathy and colonopathy, and hemorrhoids are common manifestations of GI lesions caused by portal hypertension and are associated with both acute and chronic iron deficiency anemia. However, PHPs in the intestine are rarely detected, and to date, only 6 cases of intestinal PHPs have been reported (Table 1).[2-4] Among them, 4 cases were detected in the duodenum and 1 in the descending