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CLINICAL CASE

Heterotopic gastric mucosa in the rectum: Report of a case☆

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KEYWORDS
Ectopic gastric mucosa;
Rectum;
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Abstract
Background: Ectopic gastric mucosa has been described in different locations of the digestive tract, but that of the rectum is the least frequent.
Clinical case: The case is described of a 48 year-old woman being investigated by the gastrointestinal department due to rectal bleeding and rectal tenesmus. Colonoscopy showed a diverticular cavity 3 cm, which was reported by histology as fundic-type heterotopic gastric mucosa. Barium enema and abdominopelvic CT showed a diverticular image at level of the right posterolateral wall of the rectal ampulla.

Trans-rectal diverticulectomy was performed with primary closure of the resulting mucosal defect. The surgical specimen showed areas of gastric epithelium with no signs of atypia.
Conclusions: It is not known whether the origin of heterotopic gastric mucosa occurs during foetal development or is the result of abnormal regeneration under inflammatory conditions. It is usually clinically asymptomatic or presents as haematochezia, especially in cases where gastric acid is being produced. In these cases there must be an initial treatment with proton pump inhibitors, although the definitive treatment is always surgical or endoscopic excision of the mucosa.

PALABRAS CLAVE
Mucosa gástrica ectópica;
Recto;

Mucosa gástrica heterotópica en el recto: reporte de un caso

Resumen
Antecedentes: La mucosa gástrica ectópica se ha descrito en distintas localizaciones del tubo digestivo, de todas ellas, el recto es la más infrecuente.

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Resección mucosa endoscópica

Caso clínico: Mujer de 48 años estudiada por el servicio de digestivo debido a rectorragias y tenesmo rectal. La colonoscopia apreció una cavidad diverticular de 3 cm, cuya anatomía patológica se informó de mucosa gástrica heterotópica de tipo fúndica. El enema opaco y el reporte de la tomografía computada abdominopélvica demostraron una imagen diverticular situada a nivel de la pared posterolateral derecha de la ampolla rectal.

Se practicó diverticulectomía por vía endoanal con cierre primario del defecto mucoso resultante. La pieza quirúrgica evidenció áreas de epitelio gástrico, sin signos de atipia.

Conclusiones: Se ignora si el origen de la mucosa gástrica heterotópica se produce durante el desarrollo fetal o es el resultado de una regeneración anómala, bajo condiciones inflamatorias. Clínicamente suele ser asintomática o presentarse como hematoquecia, especialmente en los casos en que es productora de ácido gástrico; en estos casos, debe hacerse un tratamiento inicial con inhibidores de bomba de protones, aunque el tratamiento definitivo es siempre la escisión quirúrgica o endoscópica de la mucosa.

Background

Although the presence of heterotopic gastric mucosa has been described from the tongue to the anus, it is rarely located in the rectum. Since it was first described in 1939 by Ewell and Jackson[1] barely fifty cases have been published on ectopic gastric mucosa in the rectum.

Clinical case

We present the case of a 48 year-old, examined in our hospital's digestive unit for rectal bleeding and tenesmus. She had a history of smoking and arterial hypertension. She had no history of colitis or rectal trauma.

The results of complementary tests showed haemoglobin levels of: 10.7 g/dl and normal carcinoebryonic antigen (CEA), colonoscopy showed a diverticular cavity of 3 cm (Fig. 1) whose pathologic anatomy reported heterotopic gastric mucosa, fundic in type. There was no evidence of colonisation by *Helicobacter pylori*. Opaque enema and abdominopelvic computed tomography showed a diverticular image 3 cm in depth, situated at the level of the right posterolateral wall, in the most caudal section of the rectal ampulla (Fig. 2). Gammagraphy did not detect any other foci of uptake in the area.

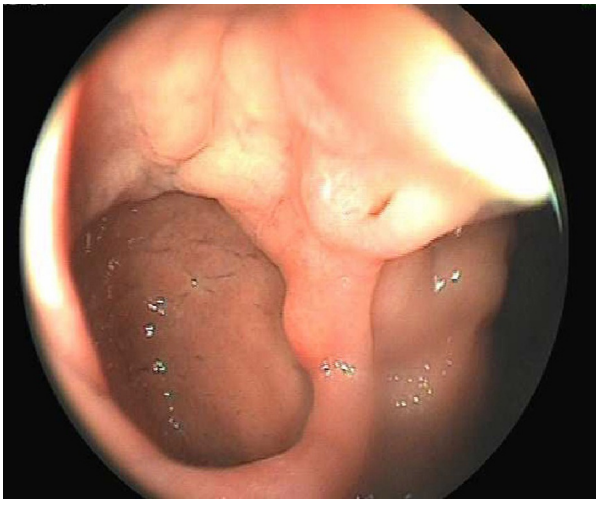

Figure 1 Colonoscopy presenting a diverticular image of 3 cm in diameter, with biopsy of heterotopic gastric mucosa.

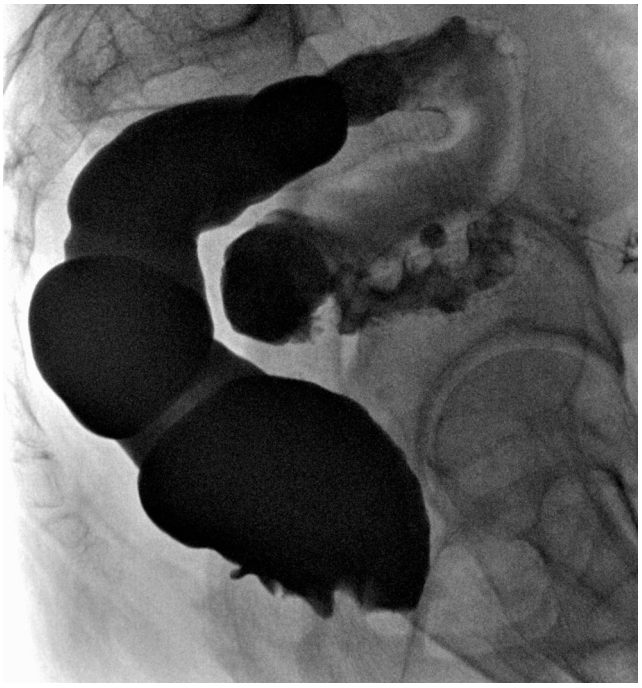

Figure 2 Opaque enema shows a diverticular image of 2 cm in depth in the most caudal section of the rectal ampulla.

In this context the patient was evaluated by the digestive unit in general surgery and it was decided to operate. The procedure was undertaken via the endoanal route, and a diverticulectomy was performed with primary closure of the resulting mucosal defect. The surgical sample showed areas of gastric epithelium with mucosecretory, parietal and principal cells with no signs of atypia. Transition with the