A Rare Esophageal Neoplasm

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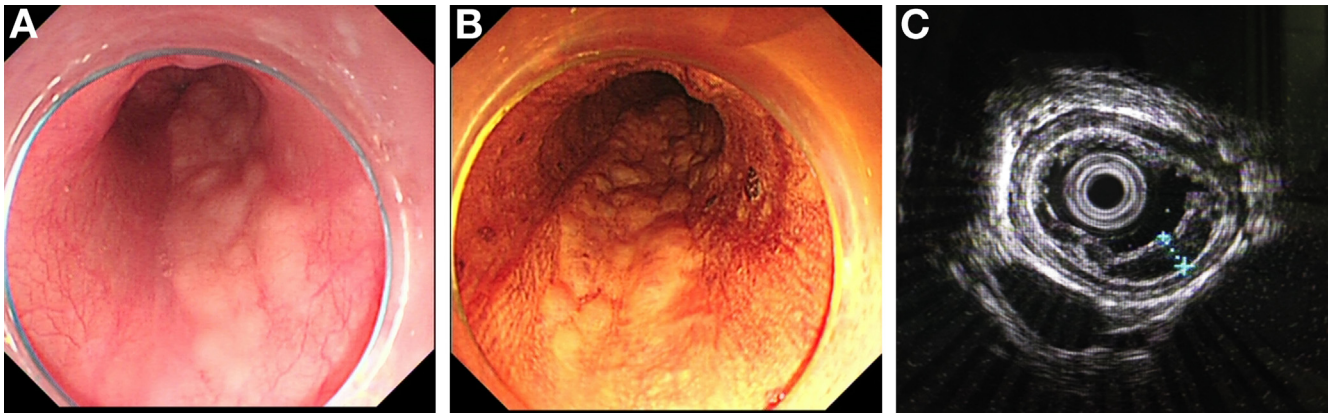

Question: A 56-year-old woman was referred to our hospital and presented with heartburn. The patient had a history of cholecystectomy, but denied any systemic symptoms. Upon physical examination, the liver, spleen, and superficial lymph nodes were not palpable. Laboratory studies showed no abnormalities. Endoscopic examination revealed a flat lesion spanning longitudinally of the esophagus 30-36 cm from the incisor teeth with a rough surface (Figure *A*), slightly stained by Lugol chromoendoscopy (Figure *B*). Endoscopic ultrasonography showed an inhomogenous hyperechoic lesion with hypoechoic zone centrally (Figure *C*). Twice endoscopic specimens obtained by biopsy forceps did not demonstrate any notable abnormal findings, except some lymphocytes. Chest computed tomography did not reveal remarkable abnormalities. Endoscopic submucosal dissection was performed.

What is the most likely diagnosis?

See the *Gastroenterology* web site (www.gastrojournal.org) for more information on submitting your favorite image to Clinical Challenges and Images in GI.

Conflicts of interest
The authors disclose no conflicts.

TL and HM contributed equally to this work.

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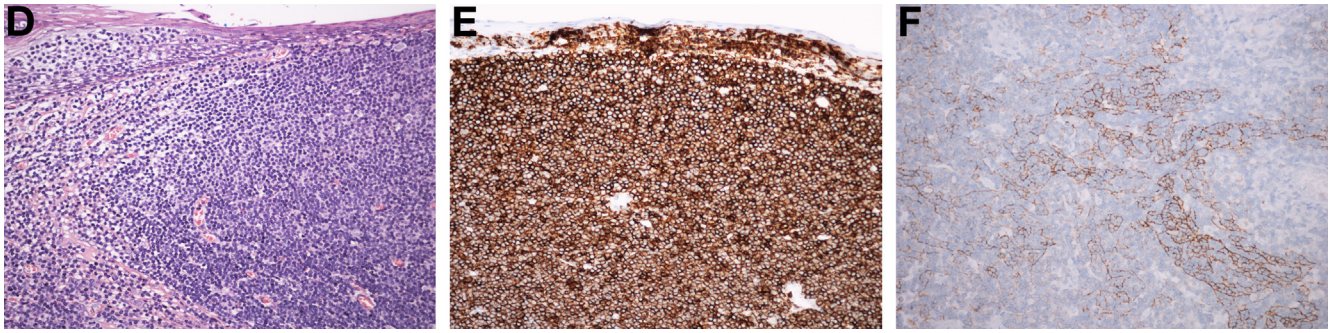
Answer to the Clinical Challenges and Images in GI Question: Image 4: Primary Esophageal Mucosa-Associated Lymphoid Tissue Lymphoma



Histologic examination showed the lesion to be composed of diffuse, small lymphoid cells, which had invaded the epithelial mucosa (Figure *D*; stain, hematoxylin and eosin; original magnification, ×200). The tumor cells were strongly positive for CD20 and CD21 reveals expanded and damaged meshworks of follicular dendritic cells (Figure *E*, *F*; stain, envison; original magnification, ×200). Based on all these findings, it was diagnosed as extranodal marginal zone B-cell lymphoma of the mucosa-associated lymphoid tissue (MALT) type. The patient received additional *Helicobacter pylori* eradication therapy because the ^{13}C-urea breath test was positive. She recovered with no recurrence during the follow-up.

MALT lymphomas, which were first described in 1983, arise from non-native lymphoid tissue acquired by gastric mucosa. The stomach is the most common site of involvement (23% of extranodal lymphomas), followed by small intestine (7.5%), but the esophagus is the rarest (∼0.2%).[1] Up to now, little has been known about the primary esophageal MALT lymphoma.[2] Symptoms vary, including dysphagia, heartburn, and tarry stool. A definite diagnosis was not easily established using specimens obtained by biopsy forceps; most were diagnosed surgically, including by endoscopic mucosal resection; however, 1 patient was diagnosed by endoscopic ultrasound-guided fine-needle aspiration.[2] Our case was diagnosed by endoscopic submucosal dissection, with the doubt of precancer from the slightly stained evidence. There has been no standard treatment and the prognosis is unclear. Local resection and *H pylori* eradication can be applied depending on the clinical features.

References

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