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Short communication

Landulocystic Gastric Polyposis

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It is about a 43-year-old patient with no past medical history who consulted for dyspeptic disorders and vomiting. The clinical examination was without abnormalities. Esophagogastroduodenoscopy revealed innumerable sessile polyps in the stomach's cardia, fundus, and body There were no polyps in the stomach antrum. H. pylori infection was not found in biopsies taken from the stomach body and antrum. A colonoscopy was performed showing the appearance of diffuse recto-colonic polyposis. The diagnosis of polyposis adenomatous familial (PAF) was retained and a genetic investigation was initiated within the family. The patient was operated on and a total prophylactic coloproctectomy was performed. The postoperative follow-up was simple. The anatomopathological study showed an appearance of rectocolic PAF without signs of degeneration. Periodic monitoring of gastric lesions was planned. But the vomiting became uncontrollable and the laboratory tests showed electrolyte disturbances which were difficult to balance (compensate) [1,2]. Surgery was decided and a total gastrectomy was performed Figure 1. Pathological examination of the operative specimen was in favor of gastric glandulocystic polyposis without signs of dysplasia or degeneration.

Fundic gland polyps associated with PAF have been detected in 20% to 84 percent of individuals. Histopathologically, On a background of generally normal stomach mucosa, they are characterized by cystically dilated, irregularly budged fundic glands. Because of the higher risk of dysplasia and malignancy in patients with an inherited polyposis syndrome, there is a definite purpose for FGP surveillance. In our case, surgery was necessary vu the impact of vomiting on the patient's quality of life and on the electrolyte balance.

Keywords: polyposis adenomatous familial, gastric glandulocystic polyposis, total gastrectomy

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Figure 1. Operative specimen showing gastric polyposis

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