Xanthelasma of esophagus and stomach

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Gastric xanthelasma, a benign condition, has been reported before; there has been no documentation of xanthelasma of the esophagus. We report a patient with xanthelasma of the stomach and esophagus. [Indian J Gastroenterol 2000;19:135]

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Xanthelasma or lipid islands of the stomach is characterized by accumulation of large foamy cells in the lamina propria. This lesion needs to be differentiated from early or signet-cell carcinoma. Lesions with which xanthelasma may coexist.

A 37-year-old woman presented with history of upper abdominal pain and recurrent vomiting for 2 months’ duration. She had lost approximately 5.5 kg over a period of 6 months; anorexia was significant. There was no history of gastrointestinal bleed. On examination, a mass was felt in the epigastrium which was confirmed on ultrasonography as a gastric mass. Upper gastrointestinal endoscopy showed multiple nodular lesions extending from the distal esophagus to the stomach involving it in its entirety and sparing the duodenum. The stomach was not distensible. The nodules were yellowish in color and size varied from 2 mm to 5 mm. We considered a diagnosis of primary lymphoma of the stomach.

Histology of the distal esophageal mucosa showed large foamy macrophages containing fine vacuoles and normal nuclei; the overlying mucosa showed mild acaenthesis (Fig). There was no cellular atypia. The gastric mucosa revealed sheets of large foamy cells in the lamina propria. There was no evidence of malignancy. A diagnosis of xanthelasma of the esophagus and stomach was made.

The term gastric xanthelasma was introduced by Kimura. The lesions are seen more frequently in men, the frequency increases with age.

Xanthelasma in the gastrointestinal tract usually occurs in the gastric antrum (68%), most frequently along the lesser curvature or as part of xanthoma disseminatum. They are seen at endoscopy in 0.06% to 6.3% of non-operated patients. The lesions appear as yellow, orange or white well-demarcated macules with irregular outline, usually sessile; they may be single or multiple, measuring up to 5 mm in diameter. Larger lesions may be nodular and protrude above the surface. Endoscopically, it is difficult to distinguish these lesions from primary lymphoma of the stomach and carcinoid. Our patient had involvement of the distal esophagus (histology unreported in literature) and also diffuse involvement of the stomach.

Histologically, xanthelasma are characterized by collections of foamy histiocytes, which have a peripheral nucleus. These cells are derived from destroyed blood cells secondary to an earlier bleed and are located in the lamina propria. The histiocytes contain neutral fat and cholesterol and are PAS and Alcian blue negative, which differentiates them from signet-ring carcinoma cells with which they may be confused. Inflammation is conspicuously absent.

The pathogenesis of these lesions is unclear; biliary reflux could be an important etiological factor. Ultrastructural studies have shown that the foam cells originate from two sources; histiocytes and smooth cells. Chemical analysis of these lesions has shown the presence of cholesterol in all cases and of neutral fat in one third. The natural history is not known, but it is probable that the nodules resolve spontaneously.

References

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