

tion. Therefore, endoscopic procedure should be performed with the attendance of an anesthesiologist as urgent tracheal intubation may be necessary. Also, the surgical team should be alerted, and operation room should be ready. Taking into

account the high probability of perforation, endoscopic retrieval may not be a good therapeutic option in such a case, and surgery may be the initial choice. Elective surgery will lead to less morbidities and shorten the duration of hospitalization.

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An unusual cause of granulomatous gastritis in an elderly patient: *Helicobacter pylori*

Yaşlı hastada granülamatöz gastritin nadir nedeni: Helikobakter pilori

To the editor

Granulomatous gastritis is a rare disease (1). The cause of granulomatous gastritis is determined with exclusion of granulomatous diseases. *Helicobacter pylori* (*Hp*) may unusually be associated with granulomatous gastritis (2,3). Our case was an elderly patient with granulomatous gastritis that recovered entirely after *Hp* eradication therapy.

A 68-year-old man presented to the department of gastroenterology with a 4-week history of epigastric pain. He did not have fever, respiratory symptoms, or diarrhea. He had no history of inflammatory bowel disease, peptic ulcer disease, sarcoidosis, or abdominal surgery. His physical examination

was normal. His complete blood count, erythrocyte sedimentation rate, blood chemistry, chest radiograph, and abdominal ultrasound were normal. Serum angiotensin-converting enzyme levels were normal. Upper gastrointestinal endoscopy showed erythema of the antral mucosa. Two gastric biopsy specimens from the antrum demonstrated chronic inflammation and non-caseating granulomas composed of epithelioid histiocytes, mononuclear cells, and multinucleated giant cells (Figure-1). *Hp* was detected by histologic examination of specimens from antrum. Terminal ileum and colon were normal endoscopically. Biopsies of ileal mucosa were normal. We determined granulomatous gastritis association with *Hp* infection. The patient was given pantoprazole 80 mg/day, amoxi-

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Manuscript received: 01.02.2012 Accepted: 11.06.2012

doi: 10.4318/tjg.2013.0549

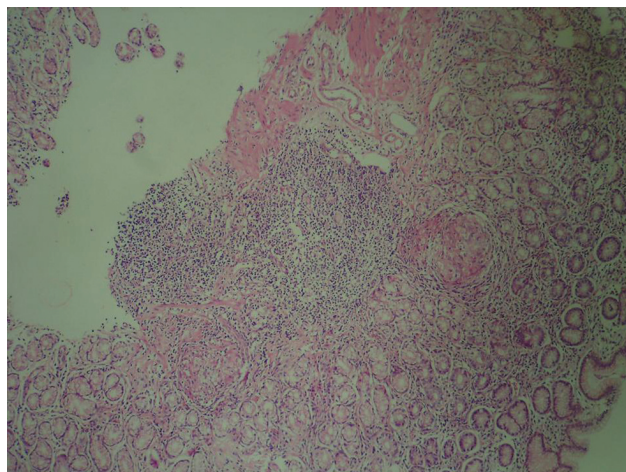


Figure 1. Non-caseating granuloma including histiocytes, mononuclear cells, and multinucleated giant cell (hematoxylin&eosin, x100).

cillin 2000 mg/day, and levofloxacin 500 mg/day for 2 weeks for treatment of *Hp* infection. The effect of the *Hp* eradication therapy was evaluated at the antral mucosa by endoscopy 3 months later and endoscopy was normal. Biopsy specimens from the antrum demonstrated chronic inflamma-

tion without any granulomas, and the tests for *Hp* were negative.

Granulomatous gastritis has been reported in 0.27% of gastric biopsy cases. According to the etiologic classification of granulomatous gastritis, the following rates have been estimated: Crohn disease (52%), isolated granulomatous gastritis (25%), foreign bodies (10%), underlying malignancy (7%), sarcoidosis (1%), Whipple disease (1%) and unclassified (3%) (4). *Hp* infection of the gastric mucosa is frequently associated with nonspecific gastritis (5). Dhillon and Sawyerr first reported an association between granulomatous gastritis and *Hp* in 1989 (6). In our case, we showed the resolution of symptoms, endoscopic findings, and granulomatous gastritis after successful *Hp* eradication therapy. The granulomas had disappeared 3 months after *Hp* eradication in our patient.

In conclusion, we have showed the probable association between granulomatous gastritis and *Hp* infection. *Hp* infection should be considered in the differential diagnosis of granulomatous gastritis. We recommend *Hp* eradication for patients with granulomatous gastritis and *Hp* infection.

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