

## Heterotopic gastric mucosa in the proximal esophagus (inlet patch) : a clinical entity with increased recognition

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### Dear Editor,

Heterotopic gastric mucosa patch can be seen in various parts of the gastrointestinal system from mouth to anus. However, esophageal heterotopic gastric mucosa patch, also known as inlet patch (IP), has been increasingly reported. IP is seen as a flat island or islands of red mucosa in the proximal third of the esophagus in endoscopic examination (1).

IP is often missed due to its location in the esophagus, just distal to the upper esophageal sphincter, making endoscopic evaluation difficult. Hence the condition is most likely to be under-reported. Nonspecific oropharyngeal symptoms are common and thought to be due to laryngopharyngeal reflux. Symptoms as well as morphologic changes associated with IP are regarded as a result of the damaging effect of acid, produced by parietal cells in the mostly fundic type of IP. In a recently published article, authors reported that dysphagia was related with the size of IP and speculated that this might be associated with larger IP causing more acid secretion (2).

In the literature, there is a proposal of a useful clinico-pathologic classification (Table 1). Asymptomatic IP requires neither specific therapy nor endoscopic surveillance. Only in symptomatic cases treatment, i.e., dilatation for (benign) strictures or acid suppression for reflux symptoms, can be recommended. Patients with low-grade dysplasia in IP might be candidates for surveillance strategies, whereas in cases of high-grade dysplasia and invasive adenocarcinoma oncological treatment strategies must be employed (3). In a well-documented histopathological study, the authors reported that oxyntic mucosa constituted the most common histologic type and the *H. pylori* infection of IP correlated with that of antrum and none of the IP biopsies showed intestinal metaplasia (4).

We want to share our clinical observation about IP before and after 2007 January (the date our department started a prospective clinical research to clarify the clinical features and importance of IP). Before that date, detection of IP is extremely rare (0.5%, 29/5899 in year 2006). When we paid special attention to detecting IP by thoroughly examining the proximal esophagus upon withdrawal of the endoscope we found a higher frequency of IP (approximately 4/100, 98/2521 in first half of 2007). This result is compatible with that of Azar *et*

Table 1. — Types of IP and their clinical relevances

TYPE OF INLET PATCH	CLINICAL FEATURE
Type 1	Asymptomatic
Type 2	Mild dysphagia or extraesophageal manifestations
Type 3	Symptomatic due to morphologic changes, i.e., esophageal strictures, webs, or esophago-tracheal fistula
Type 4	Malignant transformation via dysplasia
Type 5	Cervical esophageal adenocarcinoma

*al.* who stated the importance of detailed endoscopic examination to detect IP (5).

We believe that, endoscopic diagnosis of IP is influenced by the endoscopist's thorough examination of this entity, and thus, more time devoted to such a search may lead to higher detection rates and clarify clinical importance.

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