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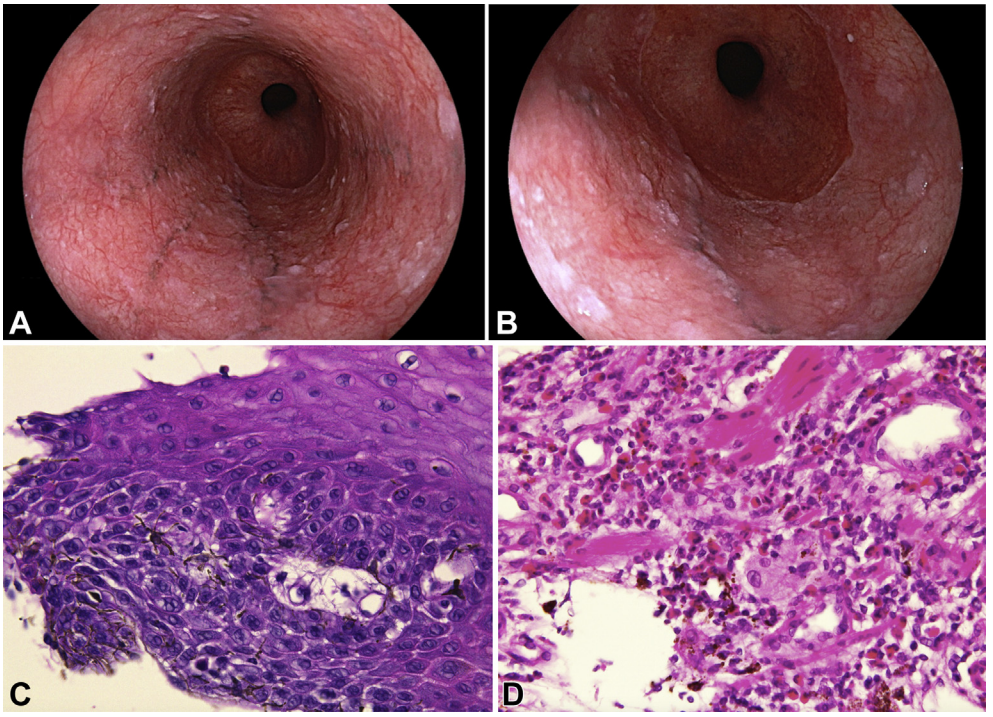
Esophageal melanosis with eosinophilic esophagitis



A 77-year-old man presented for a routine EGD without a chief complaint. He was taking medication for hypertension, and he had no history of allergies. The results of his physical examination and laboratory tests were unremarkable. EGD revealed 3 darkly pigmented flat thin linear streaks in the lower part of the esophagus (**A, B**), which appeared like the result of esophageal sclerotherapy, but they were black, and the patient had no history of esophageal varices. On targeted biopsy, histopathologic examination of the specimen with hematoxylin and eosin staining showed melanophages of brownish dark pigmentation, predominantly within the lamina propria, and melanocytes were identified in the basal layer (**C**, H&E, orig. mag. X400). Numerous eosinophils were seen at the lamina propria (**D**, H&E, orig. mag. X400). There was no tumor component.

From the endoscopic and histologic findings, we finally diagnosed melanosis of the esophagus with eosinophilic esophagitis. Until the present day, no changes in the patient's clinical symptoms and endoscopic images have occurred in more than 2 years. Proton pump inhibitors were not used for this asymptomatic condition.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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https://doi.org/10.1016/j.gie.2019.12.006

Commentary

Melanosis can occur anywhere in the GI tract. In the colon, the most common location, it is often seen in the context of laxative use/abuse and chronic colitis. In the duodenum, the condition is known as melanosis duodeni and can be seen with a variety of commonly ingested foods and medications used to treat a plethora of troubles, most notably antihypertensive agents. Melanosis duodeni commonly results from the ingestion of medications containing sulfate and iron, or a combination thereof. This patient had the unfortunate luck of having melanosis found in the esophagus, a somewhat reasonably well-understood condition.

Melanosis in the esophagus is even rarer than melanosis in the duodenum, but it has been described repeatedly. Don't mistake this finding for the so-called "black esophagus," which is a more uniform black color suggesting impending esophageal necrosis (and often warrants surgery). Melanosis duodeni can be caused by a variety of factors, including smoking, and other dietary factors and environmental locations. Although many patients find the condition upsetting, in many (most?) cases the disease does not lead to any meaningful illness.

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Endochondroma of rib showing gastric subepithelial mass-like lesion

A 54-year-old man visited our outpatient clinic because of a suggestive subepithelial tumor seen during upper GI endoscopy performed for a health checkup at another hospital. On endoscopy (**A**), an approximately 2-cm round elevated mass with bridging fold was observed in the midbody anterior wall. No specific mucosal abnormalities were observed. The result of endoscopy 3 years earlier was normal, and then the patient had no symptoms, including weight loss. Laboratory findings, including the tumor marker, were also normal. EUS was performed to determine the origin and echogenicity of the lesions. However, there was no subepithelial lesion in the stomach wall (**B**). Abdominal CT was performed because external compression was suspected. The CT disclosed an approximately 2-cm mass of rib origin, with extrinsic compression of the upper body of the stomach (**C**, axial view; **D**, coronal view). It was observed at high density in the precontrast image and was judged to originate from the left seventh rib. To manage the rib mass observed on CT, the patient underwent rib resection. Eventually, histologic examination confirmed endochondroma of the rib. The tumor was composed of mature hyaline cartilage and was adjacent to the normal bone marrow.

DISCLOSURE

All authors disclosed no financial relationships.

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https://doi.org/10.1016/j.gie.2019.12.026

Commentary

One of the main advantages of EUS is the ability to differentiate subepithelial lesions within the gastric wall from external compression. Although it is possible to see external compression clearly on EUS, in several situations the cause of the external compression is not fully revealed. Chen et al reported their experience with 55 submucosal gastric lesions caused by external compression, caused by a normal anatomic structure such as the liver, spleen, or gallbladder in 58% of their