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## Three-dimensional endoscopic optical coherence tomography imaging of cervical inlet patch

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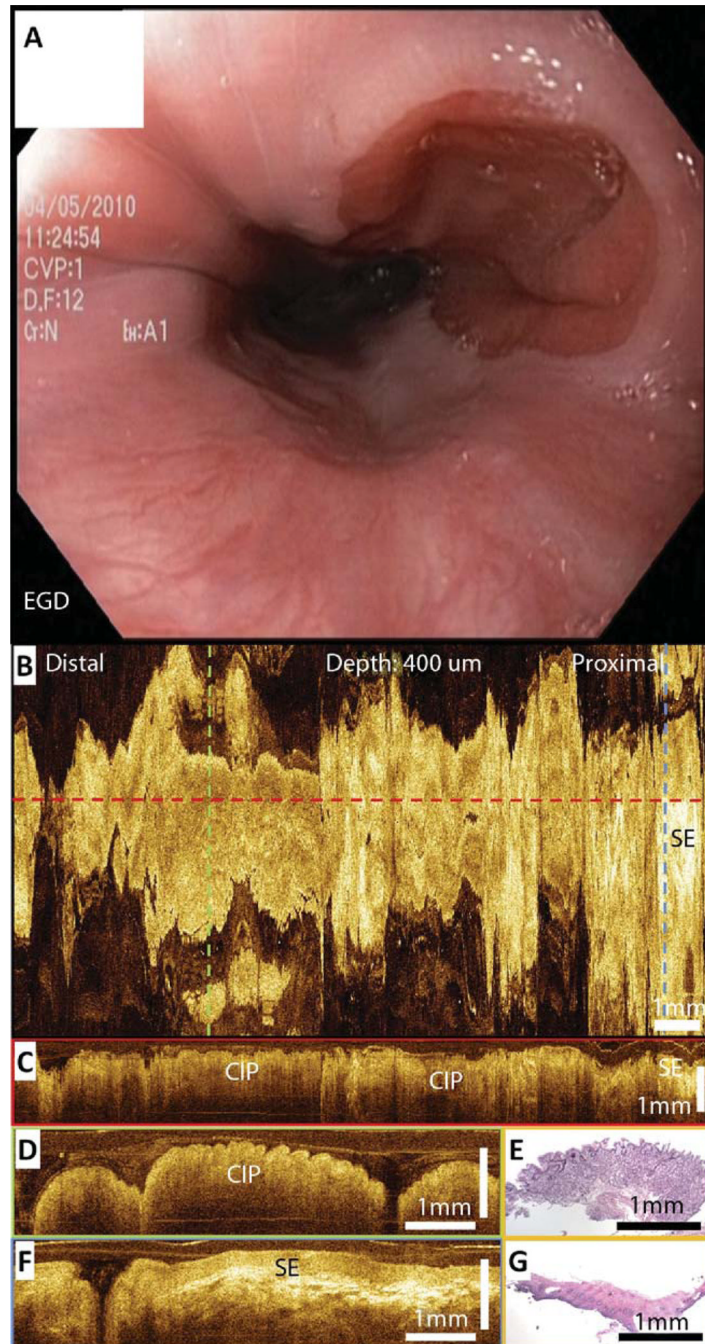
A 30-year-old white man with established Barrett's esophagus (BE) and continued symptoms of chronic severe heartburn, persistent cough, throat irritation, and asthma was referred for surveillance EGD at the VA Boston Healthcare System. During retraction of the endoscope, a pink circular lesion (**A**) was observed under white light endoscopy in the upper esophagus (spanning 20–22 cm from the incisors). Three-dimensional endoscopic optical coherence tomography (OCT) images were obtained of the region under direct visualization with white light by passing the probe through the standard accessory channel. An en face projection image (**B**) at 400- $\mu$ m depth underneath the tissue surface showed columnar epithelium consistent with a cervical inlet patch (CIP) and surrounding normal squamous epithelium (SE). Cross-sectional OCT images along the probe pull-back direction (**C**) and the probe rotation direction (**D** and **F**) clearly demonstrated columnar and squamous epithelium in the CIP region and the surrounding esophagus, respectively. Biopsy specimens

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**DISCLOSURE**

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taken from the imaged lesion confirmed the finding of CIP. The OCT features matched representative hematoxylin and eosin histology (**E** and **G**). Both esophageal and extraesophageal symptoms responded to increased antacid therapy.



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### Commentary

Proton pump inhibitor–refractory GERD and BE prompted an EGD. The authors saw CIP, scanned it with OCT, compared it with SE, and submitted this neat FP. But let’s look a few microns deeper into this case because what lies beneath (and what lies ahead) may surprise you. Heterotopic gastric mucosa, colloquially known as a cervical inlet patch, is more than a congenital endoscopic curiosity. Although most CIPs never come to the attention of the host (or the hurried endoscopist for that matter), they sure seem to have corrosive potential (odynophagia, dysphagia, and—true story—adenocarcinoma). BE and CIP may share an in utero etiology, and patients with coincident BE (like this one) may be at an increased risk of developing dysplastic Barrett’s, both in the proximal and distal esophagus. But let’s change gears because the star of the show here is the novel use of OCT. Just as US images are created by the differential acoustic reflectance of various tissue densities, OCT creates its remarkably impressionistic imagery by the differential reflection of light across ultrastructural cellular elements. Although the OCT probe is about the most highly specialized and temperamental device to ever see the inside of an accessory channel, one cannot argue that realizing the holy grail of the “optical biopsy” is close at hand. OCT is one of several experimental endoscopic imaging techniques (like confocal laser endomicroscopy and endocytoscopy) that take aim at our fairly poor ability to identify luminal dysplasia. Whether OCT will ever make it to an endoscopy center near you is less important than the continued pursuit of better ways to see. This case reminds me of the musings of the American author Og Mandino: “I will love the light for it shows me the way, yet I will endure the darkness because it shows me the stars.”

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