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PHOTO QUIZ

A strange looking face in the stomach

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CASE REPORT

A previously healthy 45-year-old male presented to our hospital with a 24-hour history of passing black stools. Physical examination revealed a low blood pressure (100/70 mmHg) and tachycardia (120 beats/min). Abdominal examination was normal. Patient said that he had lost 5 kg in the last six months. The haemoglobin concentration was 7.5 g/dl. On oesophagogastroduodenoscopy a mass with two separate ulcer craters was detected in the anterior wall of the gastric corpus (*figure 1*). After that an endosonographic examination (EUS) was performed to determine the nature of the lesion (*figure 2*).

Figure 1. *Submucosal and ulcerous lesion in the stomach*

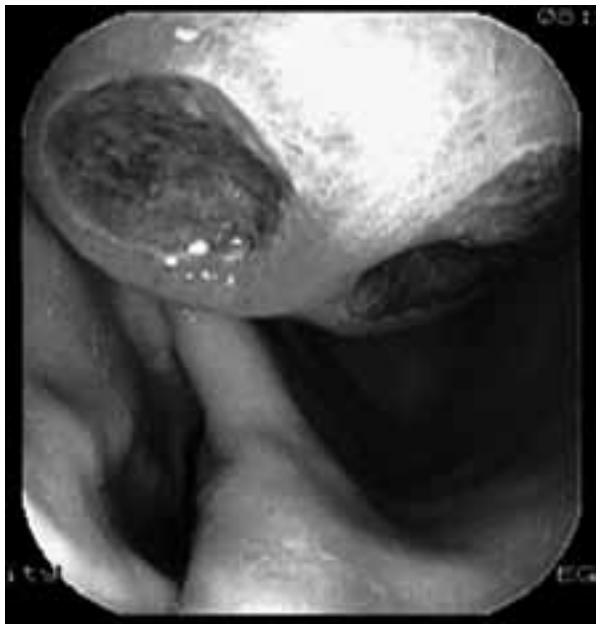
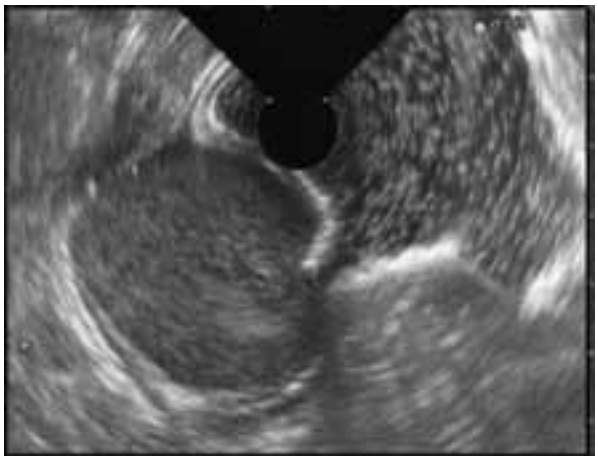


Figure 2. *Endosonography showing a hypoechoic and heterogenous lesion*



WHAT IS YOUR DIAGNOSIS?

See page 326 for the answer to this photo quiz.

ANSWER TO PHOTO QUIZ (PAGE 322)

A STRANGE LOOKING FACE IN THE STOMACH

DIAGNOSIS

On endoscopic examination (*figure 1*), a large submucosal lesion with ulcerations on it was observed. The appearance of this lesion reminded us of the head of the alien ET (Extra-Terrestrial) a movie character created by Steven Spielberg in 1982. Differential diagnosis of the lesion included tumours originating from the gastric wall (i.e. gastrointestinal stromal tumour (GIST), leiomyoma, lymphoma, neural tumours, lipoma or gastric metastasis). EUS examination revealed a large mass lesion (45 mm in diameter) originating from the muscularis propria (4th hypoechoic layer). It was hypoechoic and had a heterogenous echo pattern with cystic cavities. These findings were suggestive of a GIST with malignant degeneration.

After a surgical wedge resection, histopathological evaluation of the specimen showed that the tumour was composed of spindle cells exhibiting cytoplasmic positivity for c-KIT (CD117). The number of mitotic figures was 5 per 50 high power fields, suggesting a high-risk tumour.[1] There was no evidence of lymph node and distant metastasis.

Complete tumour resection is the definitive treatment for GIST if the tumour margins are negative and routine lymphadenectomy is not necessary since lymph node metastasis is very rare. Effective treatment of GISTs with activating mutations in the proto-oncogene c-KIT has been achieved with imatinib mesylate and published in recent studies.[2,3] KIT gene mutations are determined at a rate of 85 to 90% in GISTs and the presence of this mutation indicates a poor response to imatinib treatment.[4] In the current case, imatinib 400 mg was initiated as adjuvant therapy six weeks after the operation and patient was closely followed-up in terms of metastasis.

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