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Successful endoscopic treatment of huge gastric inflammatory fibroid polyp

Çok büyük mide inflamatuvar fibroid polibin başarılı endoskopik tedavisi

To the Editor,

Inflammatory fibroid polyp (IFP) of the stomach is a rare benign mass of unknown etiology, mostly located within the pyloric area (1-3). Clinical manifestation of large IFP can imitate symptoms of gastric cancer, such as serious epigastric pain, anemia and at times intermittent vomiting. Surgical resection of part of the stomach is the generally accepted treatment modality in these cases because of the relatively large tumor size and difficulty in differentiation from malignant polyp. There are very few reports in the literature indicating successful endoscopic submucosal resection of large colonic IFPs. To the best of our knowledge, there has been no published case in the English literature with a large gastric IFP treated by simple endoscopic polypectomy in one session. Herein, we present a large antral IFP in an elderly case with epigastric pain, anemia and intermittent vomiting due to gastric outlet obstruction, which was treated successfully by endoscopic polypectomy. Our case exemplifies the potential application of endoscopic simple snare excision even for large bulky gastric IFP in one piece without any complication.

Case. A 60-year-old female was admitted with progressively increasing epigastric pain and vomiting, which had started within the last few months. Her medical history revealed that she had a long-lasting iron deficiency anemia and previous cholecystectomy for gallstone disease. She also had maturity-onset diabetes mellitus, hypertension and obesity. She had undergone colonoscopic polypectomy a few months before in another center for a 2 cm-sized polyp, the pathology of which revealed an adenomatous polyp. Physical examination recorded a blood pressure of 220/110 mmHg, temperature of 37°C, respiratory rate of 18/minute, and heart rate of 89 per minute. There was epigastric tenderness on palpation and right subcostal surgical scar. Gynecologic examination was normal. Laboratory results indicated: hemoglobin 9.4 g/dl, white blood cell count 6700 per mm^3, platelets 390,000 per mm^3, and hypochromic and microcytic erythrocyte morphology on peripheral blood smear. Blood biochemistry was normal, and abdominal ultrasound imaging did not reveal any abnormality. An upper endoscopic examination re-

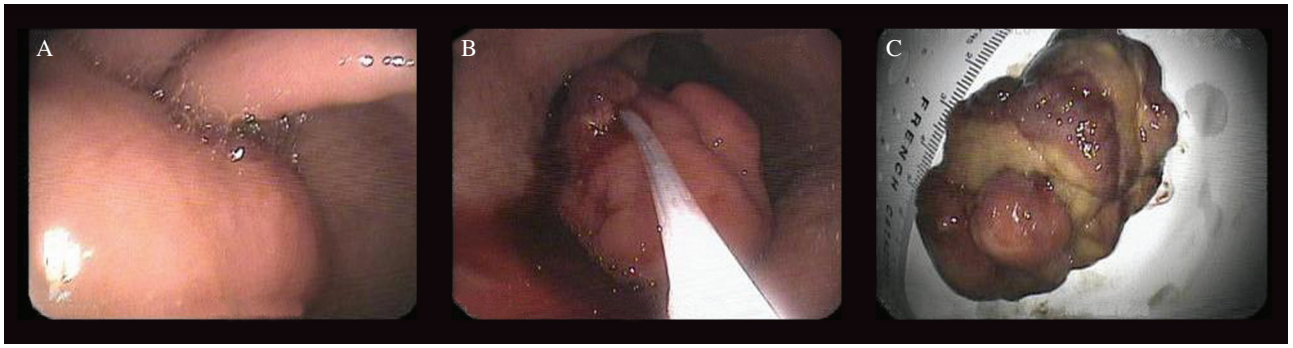

Figure 1. A. A large gastric mass located in the antrum with a stalk. **B.** Endoscopic snare excision of this mass is seen. **C.** Completely excised antral mass is shown.

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vealed a large mobile mass, measuring 6x4 cm, with a large stalk from the antrum leading to subtotal gastric outlet obstruction (Figure 1a). An endoscopic snare polypectomy (Figure 1b) was done, and the mass was excised totally (Figure 1c). There was no complication after the endoscopic procedure. Histopathology of this mass on hematoxylin and eosin staining revealed a lesion composed totally of inflammatory infiltrates rich in eosinophil leukocytes, histiocytic lymphocytes, fibroblasts, and proliferated capillaries (Figure 2). Two months after polypectomy, her hemoglobin was 13.4 g/dl. One and a half months after the excision, a follow-up upper endoscopy indicated complete eradication of the polypoid lesion, with a small ulcerated region at the polypectomy site (Figure 3).

This case with a huge gastric IFP was successfully treated with endoscopic resection. Luckily, the presence of a stalk facilitated the total endoscopic resection in this case since most patients with this mass lesion undergo subtotal gastric resection. As far as we know from the English literature, there is no previous report indicating successful endoscopic removal of a large bulky gastric IFP. Instead, successful endoscopic resection by simple polypectomy or submucosal dissection was reported in cases with large colonic IFP (4).

Inflammatory fibroid polyp is a rare mesenchymal tumor of the gastrointestinal tract (5). It has been known as a proliferating lesion with eosinophilic infiltration. Some authors believe that IFP is a localized form of eosinophilic gastroenteritis (6). The histopathology was consistent with IFP, which is composed of spindle-shaped stromal cells and an inflammatory infiltrate rich in eosinophils. There were fibroblastic cells, proliferated, irregular thick-walled vascular structures, splayed muscle fibers, and inflammatory cells (Figure 2). Immunohistochemically, the histiocytes were stained with S100 protein, the spindle cells and vascular endothelial cells were positive with CD 34, and desmin immunoreactivity was seen in splayed smooth muscle fibers. There was no staining with c-kit. These staining characteristics differentiated the polypoid lesion from gastric stromal tumor and inflammatory fibroblastic tumors (7,8).

Inflammatory fibroid polyp rarely recurs and rarely invades the muscularis propria (9). However, endosonography can help in distinguishing IFP from other submucosal tumors and can assist in determining endoscopic removal (10). Unfortunately, we did not have an endosonography facility for application in the present case. IFP lesions are mostly located at the prepyloric antrum, and the symptoms of subtotal obstruction of the gastric outlet are typical in these cases and likewise in our patient. Although surgery is the main treatment of choice in such cases with IFP, our case is a good example of successful endoscopic resection of a large gastric IFP lesion. Moreover, the endoscopic excision itself was sufficient for correction of the iron deficiency anemia in the present case.

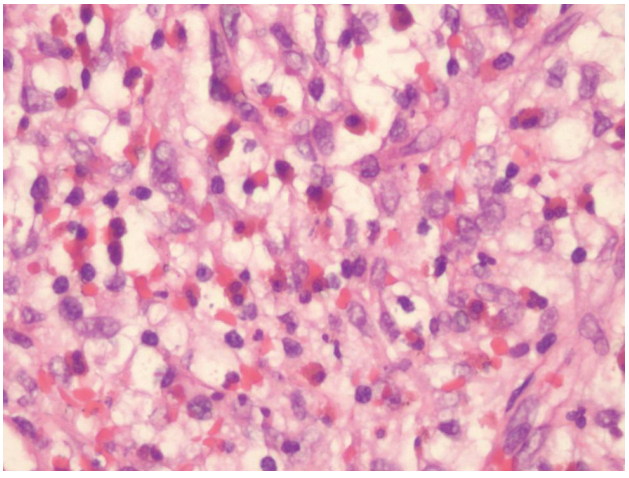

Figure 2. Mixed inflammatory infiltrates rich in eosinophil leukocytes, histiocytic lymphocytes, fibroblasts, and proliferated capillaries are seen on hematoxylin eosin staining (H & E x 460).

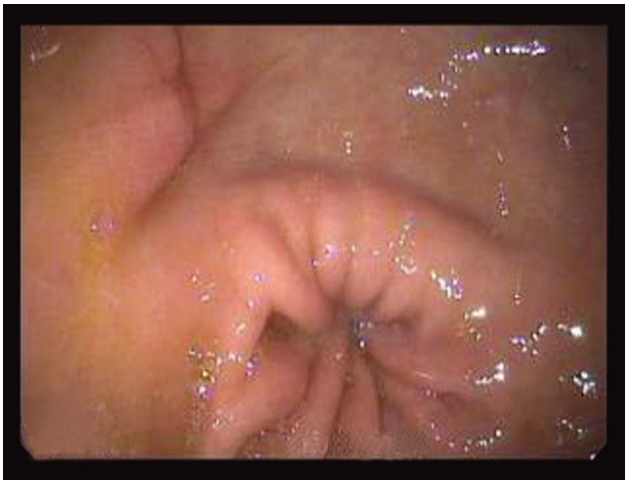

Figure 3. One and a half months after endoscopic excision, contracted ulcerated area at the previous polypectomy site is seen.

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A case of atypical celiac hepatitis presenting with hypogonadism, pancytopenia and lymphadenopathy

Hipogonadizm, pansitopeni ve lenfadenopati ile ortaya çıkan atipik çöliak hepatit vakası

To the Editor,

Celiac disease (CD) is a genetically determined autoimmune disease associated with T cell activation triggered by gliadin followed by damage to the intestinal villi (1). CD has been recognized to be a multisystem disorder that may affect the immune system, hematopoietic system, endocrine system, nervous system, and liver (2,3). Although CD involves many organs, no case has been reported in the literature in which CD manifested itself as liver, hematopoietic system and gonadal dysfunctions all in the same patient.

A 19-year-old male was admitted to the hospital with growth retardation and asthenia. He was pale. Hepatomegaly and splenomegaly were present. Bilateral axillary lymphadenopathy, measuring 0.5x0.5 cm, was detected. The patient's height was 163 cm and weight was 54 kg. Hematological and biochemical values are shown in Table 1.

Serum gonadotropin levels were significantly lower than the normal range. The gonadotropin-releasing hormone stimulation test showed hypogonadotropic hypogonadism. The patient commen-

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