are not always reliable, as the attenuation values in CT and signal analysis in MRI are variable, depending on the cyst contents (3). Endoscopic ultrasonography and endoscopic evaluations can be used for diagnosis.

The first step in the differential diagnosis of intra-abdominal cysts is determination of its organ of origin. However, because of an overlap in imaging features of intra-abdominal cysts, histologic analysis is usually necessary to establish a diagnosis (4).

In the present case, the lesion was considered to be an exophytic hydatid cyst arising from the liver due to the localization of the lesion in the abdomen, adjacent to the left hepatic lobe. However, during the surgery, it was diagnosed as a duplication cyst upon observing its association with the esophagus. In conclusion, it should be kept in mind that this cystic mass may be an abdominal duplication cyst originating from the distal esophagus.

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Gastrointestinal stromal tumor presenting as dyspareunia

Ağrılı cinsel ilişki ile kendini gösteren gastrointestinal stromal tümör

To the Editor,

A 38-year-old female Caucasian who was married for eight years complained of dyspareunia, constipation and tenesmus for the last six months. She was examined for these symptoms by the family physician and sent to a gynecologist, who found a mass with a pressure effect on the posterior wall of the vagina during the bimanual examination. In the rectal examination, a 3x4x5 cm partly mobile firm mass with regular mucosa was detected on the anterior wall of the rectum within 2-3 cm from the dentate line. Except for a low hemoglobin-hematocrit level indicating a mild anemia, the laboratory tests were not noteworthy. Carcinoembryonic antigen (CEA) and other tumor marker levels were within normal values. Magnetic resonance imaging (MRI) of the pelvis indicated a 5x4 cm mass adjacent to the posterior vaginal wall, and colonoscopy revealed a mass protruding into the rectal lumen just above the anal canal without any destruction on the mucosa (Figures 1, 2).

Suspecting that the lesion might be a gastrointestinal stromal tumor (GIST), a Tru-cut biopsy, which has the least impact on mucosal integrity, was performed. The pathologic examination disc-

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Manuscript received: 16.10.2010 **Accepted:** 09.02.2011

doi: 10.4318/tjg.2011.0300

Figure 1. Endoscopic appearance of the lesion.

losed a mesenchymal tumor, which was differentiated as GIST with the immunohistochemical studies using CD117, actin and CD34 receptors staining.

Since the lesion was very close to the sphincter complex and had a low mitotic index with a diameter less than 5 cm, a local excision of the mass was decided as the treatment. The pathologic examination revealed that the mass was composed of spindle cells that were strongly stained with CD34 in addition to CD117 and actin, but not with desmin or S-100. The patient had no further complaint of dyspareunia on her first follow-up visit.

Stromal tumors of the gastrointestinal tract are rare neoplasms. The symptoms and treatment may differ according to the size and location of the tumor. Tumors less than 2 cm in size and those with less than 5 mitoses in 50 high-power fields show a good prognosis (1). Furthermore, cellularity and atypia are also important prognostic factors. Newer prognostic classification systems also take the tumor localization into consideration (2).

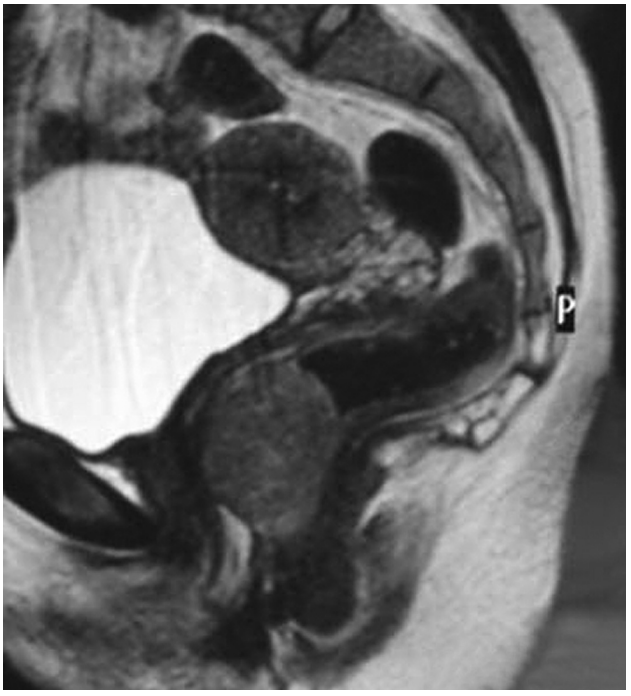

Figure 2. MRI of the pelvis revealing a 5x4 cm mass adjacent to the posterior vaginal wall.

Endoscopic snaring or excision is useful for small polyps at any level in the rectum, whereas transanal approaches have been developed to excise rectal tumors (3). Abdominoperineal resection would be reserved only for patients with high risk or large non-high-risk lower rectal GISTs.

In conclusion, in the non-high-risk group of patients, treatments with lower risk of morbidity are beneficial, but in the high-risk and intermediate-risk groups, more aggressive treatment is required to prevent recurrence.

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