Although its etiology has not been completely understood, several etiologic theories have been proposed, such as a chronic inflammatory reaction against an unknown antigen or a defect in immunoregulation resulting in an excessive proliferation of B lymphocytes and plasma cells in lymphoid organs (1,3).

Histologically, lesions of CD are divided into three types, as hyaline-vascular, plasma- cell and mixed. The most common is the hyaline-vascular type (accounting for 85%-90% of cases), and it is found in localized form in 90% of cases, but rarely in multicentric form. This type of CD predominates in the mediastinum and is very rare in the mesentery (1,6,7). Ultrasonography, CT and magnetic resonance imaging (MRI) have been proven to be helpful in diagnosing CD (3,4).

The differential diagnosis must include infectious and inflammatory lesions such as lymphadenitis, tuberculosis, sarcoidosis, toxoplasmosis, cytomegalovirus, mononucleosis, and human immunodeficiency virus (HIV). Likewise, some tumors must be included, such as lymphoma, sarcoma, metastasis, neural tumor, and thymoma (8).

The treatment for localized forms of CD is complete surgical excision (6). In our case, a complete surgical excision was made and no evidence of tumor recurrence has been detected in the two years since surgery.

In conclusion, hyaline vascular CD in localized form is very rare in the mesenteric root in the medical literature. This rare and benign disease should be considered in the differential diagnosis of mesenteric mass in the abdomen.

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Abdominal tuberculosis mimicking gastric submucosal tumor

Midenin submukozal tümörünü taklit eden abdominal tüberküloz

To the Editor,

A 40-year-old man complaining of upper abdominal pain had been referred to us for a suspected gastric tumor. The computed tomography of the abdomen revealed a 5x4 cm mass arising from the

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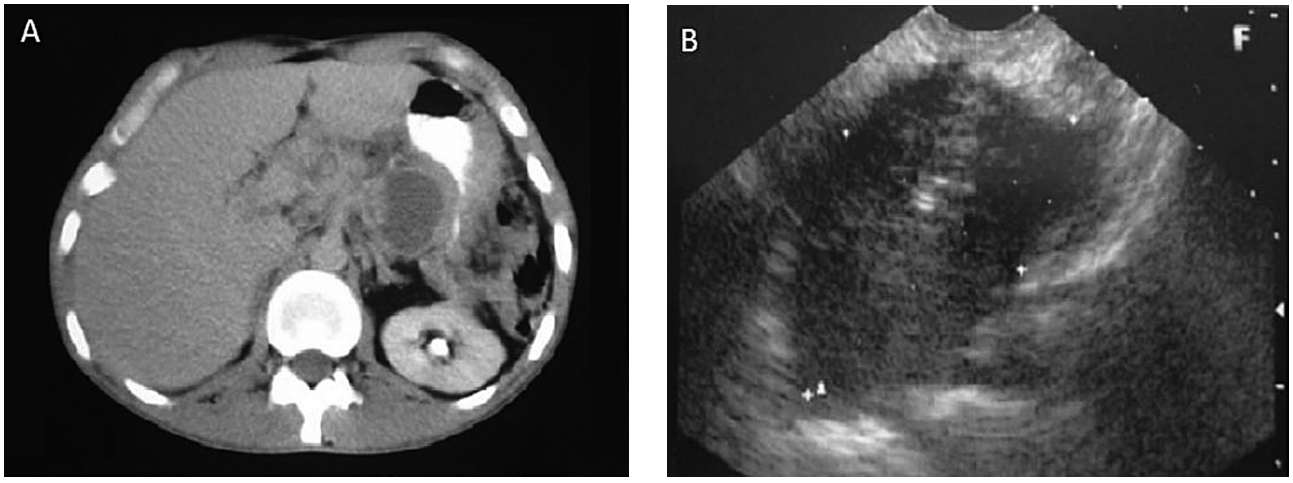

Figure 1. A. Computed tomography of the abdomen revealed a 5x4 cm mass arising from the gastric body. **B.** Endosonography showed a heterogeneous echoic lesion indistinguishable from the layers of the gastric wall, measuring about 51x31 mm.

gastric body with several accompanying lymphadenopathies (Figure 1A). His medical history included only a splenectomy after traumatic injury 20 years ago. On admission, his laboratory findings were as follows: white blood cell (WBC) count 14160/mm^3, hemoglobin (Hb) 12.7 g/dl, erythrocyte sedimentation rate (ESR) 60 mm/h, C-reactive protein (CRP) 4.42 mg/dl (0-5), alkaline phosphatase 373 U/L (40-129), and gamma- glutamyl transferase 162 U/L (8-61). Gastroscopy showed a protruding lesion, appearing submucosal, with normal-appearing mucosa except for a small ulcer on the top, about 4-5 cm in size, over the body of the stomach on the side of the lesser curvature. Endosonography showed heterogeneous echoic lesion indistinguishable from the layers of the gastric wall, measuring about 51x31 mm (Figure 1B). Endoscopic- and ultrasonography-guided biopsies were nondiagnostic. The patient underwent diagnostic laparotomy that revealed multiple intraabdominal lymphadenopathies, the largest of which was adherent to the stomach. Excisional lymph node biopsy demonstrated necrotizing granulomatous inflammation with foci of Langerhans giant cells. Acid-fast staining did not reveal any acid-fast bacilli, but a polymerase chain reaction (PCR) test for tuberculosis was positive. Thus, a diagnosis of tuberculous lymphadenitis was made.

Abdominal tuberculosis may involve the gastrointestinal tract, peritoneum, lymph nodes, or solid viscera; however, the peritoneum and abdominal lymph nodes are the most common sites (1). Tuberculous lymphadenitis can mimic malignancy, especially when adherent to adjacent organs. PCR test of the biopsy specimen provides a faster, alternative route for diagnosis with high specificity (2).

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