Gastric inflammatory myofibroblastic tumor masquerading as a pancreatic cystic neoplasm

A 56-year-old man presented with epigastric pain since 2 weeks. Esophagogastroduodenoscopy (EGD) revealed a 3-cm submucosal mass in the posterior wall of the gastric body. Abdominal ultrasound showed a multilocular cystic lesion (10 × 6 × 9 cm) in the pancreatic tail. Endoscopic ultrasound (EUS) confirmed a multicystic lesion arising from the pancreas (**Fig. 1**).

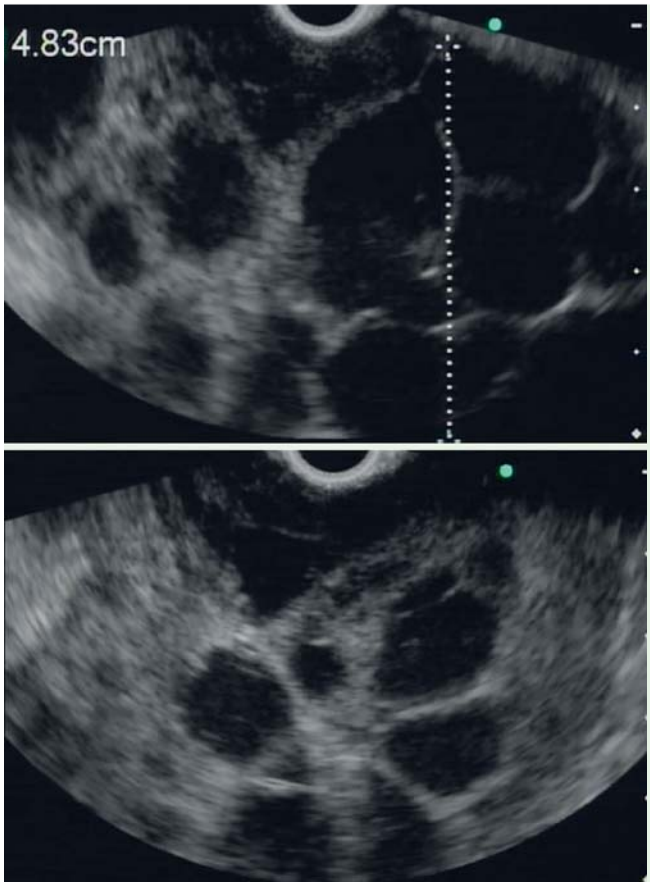

Fig. 1 Endoscopic ultrasound showing a multicystic lesion intermixed with a solid tumor.

The cysts were macrocystic in nature, ranging from 1 cm to 2 cm in size, and were intermixed with solid tumor. There was no evidence of internal calcifications or connection to the pancreatic duct. The EUS features were suggestive of a mucinous cystadenocarcinoma of the pancreas. However, a subsequent computed tomography scan revealed that the multilocular lesion was arising from the posterior wall of the stomach; this was confirmed on laparotomy (**Fig. 2**).

Macroscopically, the tumor was a lobulated, circumscribed mass with a mix of solid and cystic components (**Fig. 3**).

Histologically, it consisted of proliferating spindle cells in a fibromyxoid stroma, admixed with a moderate amount of mixed inflammatory cellular infiltrate, compatible with a gastric inflammatory myofibroblastic tumor (IMT).

IMTs are rare neoplasms in adults. Microscopically, they are composed of spindle cells with abundant cytoplasm on an inflammatory background [1]. The diagnosis of IMT is often difficult and there are scarce reports of the EUS appearances. A well-defined hypoechoic mass arising from the submucosa, similar to gastrointestinal stromal tumors, has been described [2,3]. However, a multilocular cystic appearance along with solid components has not been previously documented in the literature. In the present case, the lesion was initially mistaken to be a pancreatic cystic neoplasm and a ret-

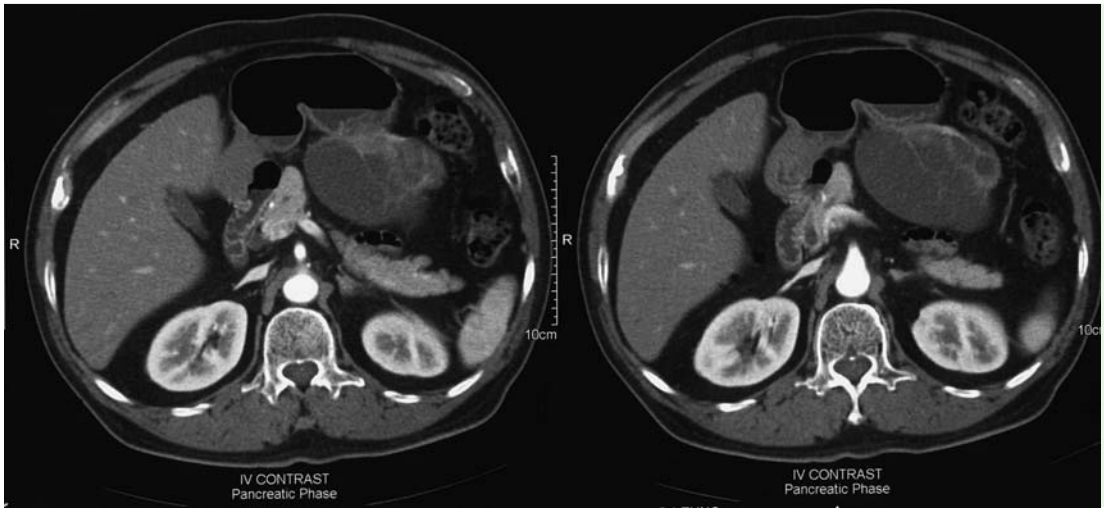

Fig. 2 Computed tomography (CT) appearances of the gastric inflammatory myofibroblastic tumor.

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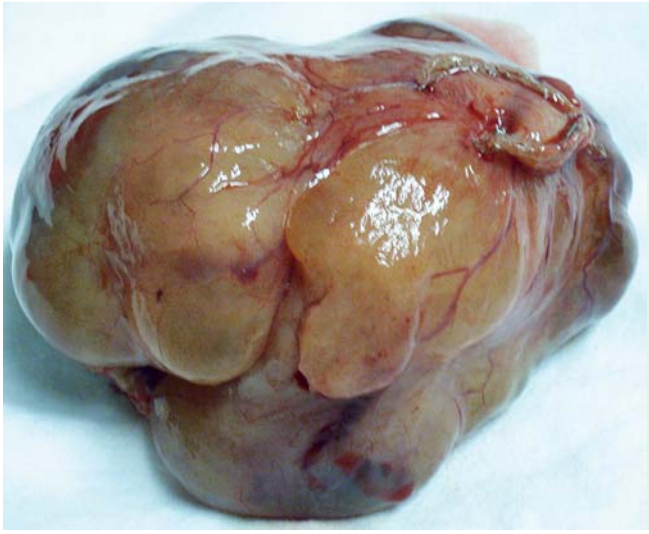

Fig. 3 Macroscopic appearance of the lobulated, circumscribed mass with mixed solid and cystic components.

rospective review of the EUS images demonstrated that the tumor was indeed arising from the gastric wall. The mainstay of treatment for IMT is resection with clear margins [4,5]. After complete resection, the prognosis of IMT is generally good with a low risk of distant metastasis [1,4,5].

Competing interests: None

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A. K. W. Fong, A. Y. B. Teoh, P. W. Y. Chiu, S. K. H. Wong, E. K. W. Ng
Division of Upper Gastrointestinal Surgery, Department of Surgery, Prince of Wales Hospital, Chinese University of Hong Kong, Hong Kong SAR, China

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Corresponding author

E. K. W. Ng
Department of Surgery
Prince of Wales Hospital
Shatin New Territories
Hong Kong SAR
China
Fax: +852-2637-7974
endersng@surgery.cuhk.edu.hk

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