A healthy 26-year-old woman presented with a year of intermittent epigastric pain but no other symptoms. Upper gastrointestinal endoscopy showed, on the anterior wall of the gastric body, a submucosal, elevated, well-defined lesion measuring 3 cm in diameter, with normal overlying mucosa (Fig. 1).

Endoscopic ultrasonography showed a hypoechoic lesion arising from the muscularis propria, without deep involvement (Fig. 2), compatible with a gastrointestinal stromal tumor (GIST). The patient was operated on. A well-defined 2-cm tumor, without serosal involvement, was found on the anterior wall of the gastric body. A partial gastrectomy was done with 1-cm margins (Fig. 3). The patient was discharged without problems.

The biopsy showed in the muscularis propria a well-defined stromal tumor made of vascular structures, covered by a single layer of endothelial cells, and with dense cellular proliferation around the vascular structures, with low mitotic rate (one or two mitoses per 50 high-power fields) and without necrosis. Immunohistochemical staining was positive for smooth muscle actin. The conclusion was that it was a glomangioma (Fig. 4 a, b).

Glomus tumors are rare. Nearly 75% of glomus tumors are localized in the hands, under the nails [1]. They originate from the normal myoarterial apparatus and are constituted by an afferent arteriole and vascular channels with endothelial cells, surrounded by cuboidal cells [2]. Just 2% of benign gastrointestinal tumors are vascular tumors; most are glomus tumors [3]. The majority are asymptomatic, and the diagnosis is incidental; upper gastrointestinal bleeding and ulcerous syndrome are the most frequent symptoms. Glomus tumors have a female predominance (2.5:1). The majority are benign and single, but the malignant potential is unpredictable [4,5]. The peak incidence of glomus tumors is in the sixth decade of life. Diagnosis is generally done after surgery. During endoscopy, a submucosal mass similar to smooth muscle is generally found. Computed tomography (CT) shows an enhanced pattern with contrast. Histological studies show a low mitotic rate, positive staining for actin and calponin, and negative for c-kit, chromogranin and common leucocyte antigen, which differentiate GIST, carcinoids, and lymphoma respectively, the three differential diagnoses. The management is surgical resection for final diagnosis and treatment [5].
F. Orellana1,2,3, C. Onetto2, P. Balbontín1,2, D. Videla1,2, L. Manriquez1,2, R. Plass1,3, R. Araya3, R. Sepúlveda1,2, R. Saenz4, H. Ríos1,2

1 Department of Surgery, Hospital Militar de Santiago, Santiago, Chile
2 Department of Surgery, Universidad de Los Andes, Santiago, Chile
3 Department of Gastroenterology, Hospital Militar de Santiago, Santiago, Chile
4 Department of Gastroenterology, Clínica Alemana de Santiago, Santiago, Chile

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Corresponding author
Franco Orellana Gárate, MD
Department of Surgery
Hospital Militar de Santiago
Avenida Larraín 9100
La Reina
Santiago
Región Metropolitana 7560872
Chile
Fax: +56-2-8811374
fforella@gmail.com

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