

Gastric gastrointestinal stromal tumor presenting with an intraluminal draining abscess and left pleural effusion

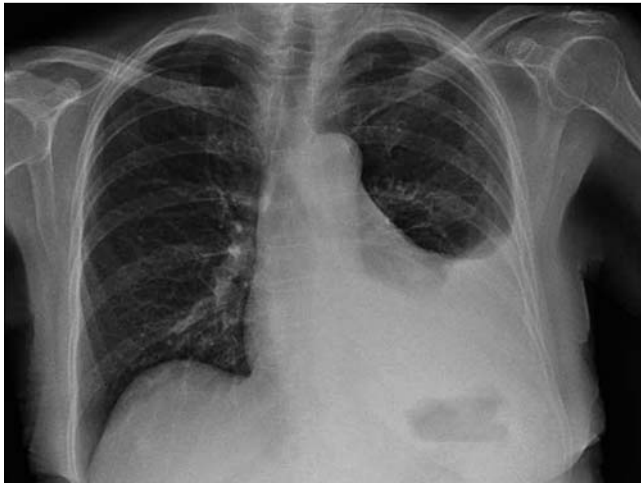


Fig. 1 Chest radiograph in a 77-year-old woman with a 2-month history of anorexia, fever, and weight loss showing a left pleural effusion.



Fig. 3 Abdominal contrast-enhanced computed tomography (CT) scan showing a mass of 14 × 12 × 11 cm, with central necrosis, originating in the posterior gastric wall and in contact with the spleen, suggestive of a gastrointestinal stromal tumor (GIST) complicated by an abscess.

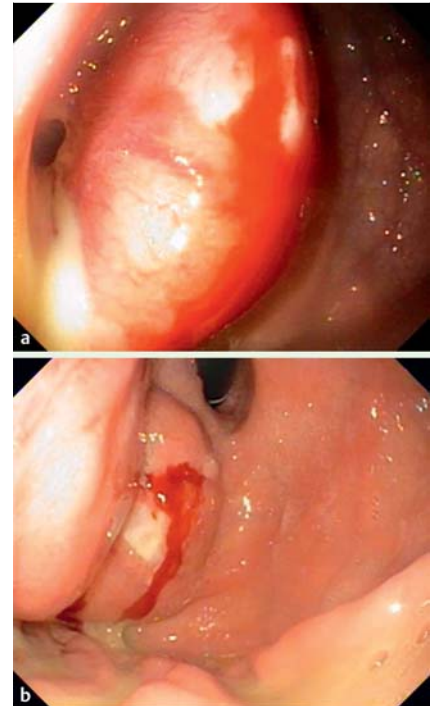
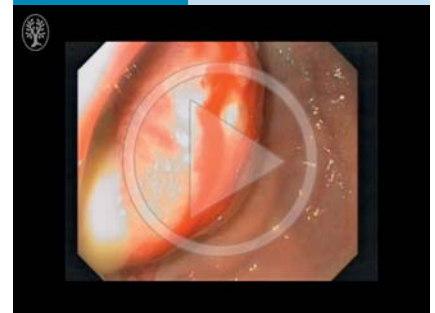


Fig. 2 Images from upper gastrointestinal endoscopy showing a bilobed mass of 5 cm in the posterior aspect of the gastric fundus that was spontaneously discharging a large amount of purulent material from a small central orifice.

Video 1



Upper gastrointestinal endoscopy showing a bilobed mass of 5 cm in the posterior aspect of the gastric fundus that was spontaneously discharging a large amount of purulent material from a small central orifice.

A previously healthy 77-year-old woman presented with a 2-month history of anorexia, fever, and weight loss. On physical examination, she had diminished breath sounds in the lower two-thirds of the left hemithorax; her chest radiograph revealed a left pleural effusion (► **Fig. 1**). Laboratory work-up showed a hemoglobin of 9.6 g/dL, C-reactive protein (CRP) of 9.5 mg/dL, and erythrocyte sedimentation rate (ESR) of 70 mm/hour. Because of a family history of pulmonary tuberculosis, a tuberculous pleural effusion was suspected.

A thoracentesis and pleural biopsy were performed, which revealed clear pleural fluid with the characteristics of an exudate, without malignant cells. A thoracic contrast-enhanced computed tomog-

raphy (CT) scan incidentally showed a large gastric mass, with no fistulous tract to the pleura. Upper gastrointestinal endoscopy showed a bilobed mass of 5 cm in the posterior aspect of the gastric fundus that was spontaneously discharging a large amount of purulent material from a small central orifice (► **Fig. 2**; ► **Video 1**). For better characterization and staging, an abdominopelvic contrast-enhanced CT was performed, which showed a mass of 14 × 12 × 11 cm, with central necrosis, originating in the posterior gastric wall and in contact with the spleen, suggestive of a gastrointestinal stromal tumor (GIST) complicated by an abscess (► **Fig. 3**). No nodal or distant metastases were seen. Forceps biopsies of the mass were inconclusive and no infectious agent was isolat-

ed in either pleural or gastric fluids, including from culture for *Mycobacterium tuberculosis*. The patient was put on antibiotics and an urgent surgical approach was planned.

A superior polar gastrectomy and splenectomy were performed, with histology showing a high grade gastric GIST (positive on immunostaining for CD34, CD117, and DOG1, with <5 mitosis/50 high power fields [hpf], and Ki-67 20/50 hpf) with negative surgical margins. The patient was started on adjuvant therapy with imatinib. Very few cases of gastric GIST complicated by an abscess have been reported in the literature [1–5]. To the best of our knowledge, this is the first case presenting with a large pleural effusion.

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Competing interests: None

**Mariana Ferreira Cardoso¹,
Luís Carvalho Lourenço¹,
Ana Maria Oliveira¹, José Pedro
Boléo-Tomé², Jorge Reis¹**

¹ Gastroenterology Department, Hospital Professor Doutor Fernando Fonseca, Amadora, Portugal

² Pneumology Department, Hospital Professor Doutor Fernando Fonseca, Amadora, Portugal

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Corresponding author

Mariana Ferreira Cardoso, MD
Gastroenterology Department
Hospital Professor Doutor Fernando Fonseca
IC-19, Venteira
Amadora 2720-276
Portugal
marianafcardoso@gmail.com