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

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 tomography (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 (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 isolated.
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.

Endoscopy_UCTN_Code_CCL_1AB_2AD_3AB

Competing interests: None

References


5 Abdulmaged M, Musaad AM, Arabi NA et al. Gastric GIST with chondroid differentiation presented with gastric abscess – A case report and literature review. Arab J Gastroenterol 2016; 17: 56–59

Bibliography

DOI http://dx.doi.org/10.1055/s-0042-120710

Endoscopy 2016; 48: E399–E400 © Georg Thieme Verlag KG Stuttgart · New York

ISSN 0013-726X

Corresponding author

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