A 69-year-old man presented with a submucosal tumor in the anterior wall of the lower body of the stomach (Fig. 1). He reported no obvious discomfort. His medical history was significant for hypertension, which was controlled by oral administration of amlodipine. Physical examination detected no obvious abnormalities. Endoscopic ultrasound showed a solid cystic lesion, which had a clear boundary and originated from the muscularis mucosae (Fig. 2). Enhanced computed tomography confirmed the presence of a low-density lesion in the stomach (Fig. 3). At the patient’s request, we performed endoscopic resection to determine the nature of the lesion (Video 1). Complete resection of the lesion was achieved (Fig. 4). There was no bleeding or perforation. Pathology showed cystic dilatation of the gastric glands, with submucosal invasion (Fig. 5). Immunohistochemical studies were negative for CD34 and CD117 but positive for smooth muscle action (SMA) and desmin. Therefore, the diagnosis of gastritis cystica profunda (GCP) mimicking submucosal tumor was made. The patient fasted for 24 hours and received antibiotic prophylaxis and proton pump inhibitors. He began to drink after 1 day and reported no obvious discomfort. He recovered uneventfully and was discharged after 3 days.
aminations. Gastrointestinal stromal tumor and neuroendocrine tumor are common types [1]. In this case, we detected a rare case of GCP mimicking a submucosal tumor, which presented as a solid cystic lesion in the muscularis mucosae and had invaded the submucosal layer. Since GCP may cause abdominal pain and gastrointestinal bleeding, and may be associated with gastric malignant lesions, surgical resection has become an important treatment [2]. Our experience suggests that endoscopic resection can be an alternative for GCP.

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Competing interests

The authors declare that they have no conflict of interest.

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