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).

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-

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

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

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Fong AKW et al. Gastric inflammatory myofibroblastic tumor... Endoscopy 2010; 42: E231–E232
Prospective 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

References
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