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. 4a, 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].

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References

1 Agawa H, Matsushita M, Nishio A, Takakuwa H. Gastric glomus tumor. Gastrointest Endosc 2002; 56: 903


Bibliography

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