

Endoscopic drainage of gastric wall mycetoma



Fig. 1 An encapsulated fluid collection (34 mm × 20 mm) probably within the gastric wall, shown at computed tomography (CT) in a 69-year-old patient who had previously undergone surgical necrosectomy for acute hemorrhagic necrotizing pancreatitis complicated by a pancreatic fistula.



Fig. 2 At endoscopic ultrasound (EUS) the mycetoma appears as a submucosal hypoechoic and inhomogeneous mass located in the lesser curvature of the gastric body-fundus.



Fig. 3 Drainage of the mycetoma using a precut needle and cannulotome; a dense whitish fluid begins to flow.

A 69-year-old patient was referred to our unit for further investigation of an encapsulated fluid collection (34 mm × 20 mm) detected within the gastric wall at abdominal computed tomography (CT) (► **Fig. 1**).

The patient had previously undergone surgical necrosectomy for acute hemorrhagic necrotizing pancreatitis complicated by a pancreatic fistula. In the late post-operative course he had developed fever during antibiotic treatment with mero-

penem that he had been receiving for 15 days, and CT revealed the encapsulated collection described above.

An upper gastrointestinal endoscopy was done. This showed an elevated lesion covered by normal-appearing mucosa located on the lesser curvature of the gastric fundus-body. Endoscopic ultrasound (EUS) showed a submucosal hyperechoic inhomogeneous mass (► **Fig. 2**). EUS-guided fine needle aspiration (FNA) with a 19G needle was performed. Histological

examination demonstrated the presence of necrotic tissue, inflammatory cells, and fungal hyphae. The mycetoma was drained under endoscopic visualization (► **Fig. 3**), using a precut needle (HPC-2; Cook Medical, Limerick, Ireland) and a cannulotome (CCPT-25; Cook Medical), with flow of a dense, whitish, partially corpusculated fluid from the collapsing collection. Saline solution lavages were done in order to ensure the complete emptying of the mycetoma. The patient's fever quickly resolved after the procedure and the lesion had completely disappeared on follow-up CT scan (► **Fig. 4**).

In 1982 Cipollini et al. [1] described, in a patient with previous partial gastrectomy, an atypical gastric candidiasis that endoscopically presented as a large mass located in the gastric stump. Gastric candidiasis usually looks like multiple small white plaques [2] or pseudomembranous exudate [3] surrounded by hyperemic, edematous, and friable mucosa, but erosions [4], ulcers [5], and nodules have also been described.

Our case is notable because of the endoscopic appearance of a submucosal fungal mass, rather than the usually reported presentation, and its noninvasive drainage that avoided surgical treatment in this frail patient.

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Fig. 4 At follow-up computed tomography (CT) scan the mycetoma had completely disappeared.

Bibliography

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