A 66-year-old white man was referred following visualization of a duodenal mass on endoscopy. The patient had presented to his primary physician complaining of a 6-week history of nausea, vomiting, 20-pound unintentional weight loss, and melena. Initial physical exam revealed diffuse abdominal pain. Laboratory work-up revealed normocytic-normochromic anemia (Hb 9.4 g/dL), abdominal ultrasound showed a distended gallbladder, and abdominal computed tomography scan findings were negative. Esophagogastroduodenoscopy (EGD) revealed a bleeding pedunculated lesion (2×2 cm) in the duodenum. The lesion was injected with epinephrine 1:10 000, and the patient was referred to our center, the University of Alabama at Birmingham Hospital.

Repeat EGD revealed a superficially ulcerated semipedunculated lesion (Fig. 1a). The lesion was resected using advanced resection techniques, and the defect was closed using two clips. Key steps in the resection were creation of an adequate submucosal cushion, lifting of the lesion, incising around the base using endoscopic submucosal dissection techniques, and performing endoscopic mucosal resection. Histopathology revealed an inflammatory fibroid polyp (IFP), or Vanek’s tumor, with free margins (R0) (Fig. 1b–d). The patient had a satisfactory postoperative course, and remained asymptomatic at the 6-month follow-up.

This case is of interest for several reasons. First, it demonstrates IFP in the duodenum, which is rare. IFPs are rare submucosal lesions arising from a reactive, benign, granuloma-like process of the gastrointestinal tract [1,2]. Common locations include the stomach (70%), ileum (19%), and colon (6%) [3,4], but occurrence in the duodenum is rare [3,4]. Second, a detailed endoscopic image of this tumor was obtained. Most previous publications lack endoscopic documentation. IFPs are semipedunculated or sessile lesions covered by normal mucosa with occasional superficial ulceration, and measure 2–5 cm in diameter [4,5]. Microscopically, they contain spindle cells, vascular and fibroblastic proliferation, with eosinophilic infiltration. Immunohistochemistry distinguishes them from gastrointestinal stromal tumors, as IFPs are CD-34 and vimentin positive but CD-117 negative. Finally, endoscopic resection was demonstrated to be effective in removing the IFP. However, larger lesions should be removed surgically.

In summary, this case demonstrated the endoscopic and histologic characteristics of duodenal IFP, and showed that endoscopic resection solves the partial gastric outlet obstruction and gastrointestinal bleeding.

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