Endoscopic dissection of a symptomatic giant gastric leiomyoma arising from the muscularis propria

Gastrointestinal (GI) subepithelial masses represent a heterogeneous group of lesions, ranging from benign to malignant, for which management is sometimes challenging [1, 2]. We report the case of an 85-year-old woman, with a history of coronary artery disease and chronic atrial fibrillation being treated with anticoagulant therapy, who underwent urgent upper GI endoscopy for hemorrhagic shock and melena. During this procedure, a giant, 15-cm, non-pedunculated mass that was ulcerated on top was found at the greater curvature of the anterior wall of the stomach (Fig. 1). The patient then underwent radial endoscopic ultrasonography (EUS; GF-UE160-AL5; Olympus), which showed a hypoechoic homogeneous intramural mass that was arising from the muscularis propria and was suspected to be a leiomyoma (Fig. 2). In order to achieve a definitive diagnosis, EUS with fine needle aspiration (FNA) was performed (GF-UCT180; Olympus) using a 22-gauge needle (Expect-SlimLine; Boston Scientific). Histology and immunohistochemical staining revealed that the specimen was compatible with a leiomyoma (SMA positive, CD117 and CD34 negative). Total body computed tomography (CT) excluded metastatic disease.

Because this was a symptomatic hemorrhagic lesion and there was a need to continue anticoagulant therapy, an endoscopic dissection was performed. We used the HybridKnife T-type (ERBE Elektromedizin GmbH) and a solution composed of 250 mL normal saline, 2 mL indigo carmine, and 1 mL epinephrine. The procedure took 115 minutes and resulted in an en bloc specimen, with no complications occurring (Fig. 3; Video 1). However, because of its size, it was not possible to retrieve the whole lesion, which resulted in it being completely digested by gastric secretions by the following day (Fig. 4).

Low molecular weight heparin was re-introduced 24 hours after the procedure and the patient was discharged 2 days later. Upper GI endoscopy and EUS performed 3 months later revealed a regular scar, without any remnant pathological tissue. This case illustrates the feasibility and safety of endoscopic dissection of a symptomatic giant gastric leiomyoma, even in a high risk patient who was receiving ongoing anticoagulant therapy, in whom surgery would have carried considerable risk. Moreover, EUS-FNA achieved an accurate evaluation of the lesion’s layer of origin and its histopathologic characteristics, thereby allowing a definitive diagnosis to be made and the appropriate therapeutic option to be chosen.

Endoscopy_UCTN_Code_CCL_1AB_2AD_3AB

Competing interests

None
The Authors

Mauro Manno1, Paola Soriani2, Vincenzo G. Mirante1, Giuseppe Grande2, Flavia Pigò2, Rita L. Conigliaro2
1 Digestive Endoscopy Unit, Azienda USL Modena, Ramazzini Hospital, Carpi, Italy
2 Rete Integrata Provinciale di Endoscopia Digestiva, Baggiovara Hospital, Modena, Italy

Corresponding author

Paola Soriani, MD
Digestive Endoscopy Unit, Azienda USL Modena – Ramazzini Hospital, Via Guido Molinari, 2, 41012 Carpi (MO), Italy
Fax: +39-059-659500
paola.soriani@gmail.com

References


Bibliography
DOI: http://dx.doi.org/10.1055/s-0043-103402
Endoscopy 2017; 49: E141–E142
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

▶ Fig. 3 Endoscopic views showing: a the whole lesion after endoscopic dissection; b the appearance of the resection site immediately after endoscopic dissection.

▶ Fig. 4 Endoscopic view of the resection site on the day following the procedure.