

Resection of a gastric fibroid inflammatory polyp by means of endoscopic submucosal dissection: how deep is deep enough?

Georgios Mavrogenis^a, Michel Herin^b, Milena Del Natale^a, Hocine Hassaini^a

Site Notre Dame, Grand Hôpital de Charleroi, Charleroi; Institut de Pathologie et de Génétique, Gosselies, Belgium

Inflammatory fibroid polyps (FIP) are rare mesenchymal tumors associated with mutations of the platelet-derived growth factor- α . They derive from the submucosal layer and are mainly composed of loose connective tissue, vessels and an eosinophilic inflammatory component. They are found throughout the gastrointestinal tract, but most commonly in the gastric antrum and ileum. Macroscopically, they present as large polypoid lesions of 3-20 cm in size that maybe pedunculated and ulcerated. Case series and case reports have demonstrated the efficacy of standard endoscopic techniques with snares and most recently with endoscopic submucosal dissection (ESD) in 5 cases [1,2]. We would like to share our experience in an asymptomatic 60-year-old woman who underwent ESD resection of a 4x3 cm pedunculated FIP located at the gastric antrum (Fig. 1, 2). The procedure was uneventful and macroscopically the lesion seemed to be completely resected. Surprisingly, the histology report showed positive deep margins. Due to the benign course of these lesions no additional surgery has been suggested and at one year of follow up there are no signs of endoscopic or histologic recurrence. This case illustrates that FIP may expand deep into the submucosal layer beyond the reach of invasive techniques such as ESD. Although the risk of recurrence is minimum, positive deep margins should prompt endoscopists for postoperative follow up since there is at least one report of tumor recurrence after endoscopic resection that was detected at 1 year of follow up [3].

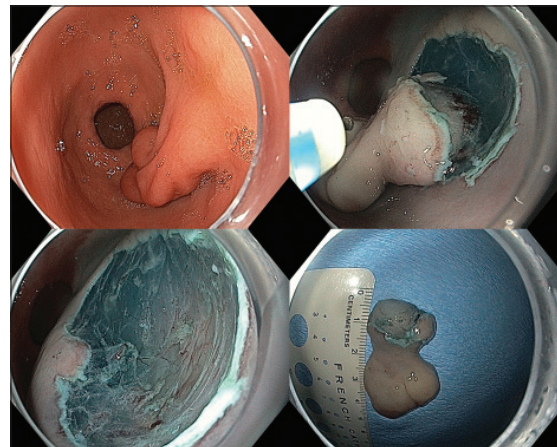


Figure 1 Pedunculated submucosal lesion located at the antrum. The lesion was resected by means of endoscopic submucosal dissection techniques (Dual Knife, Olympus, Belgium)

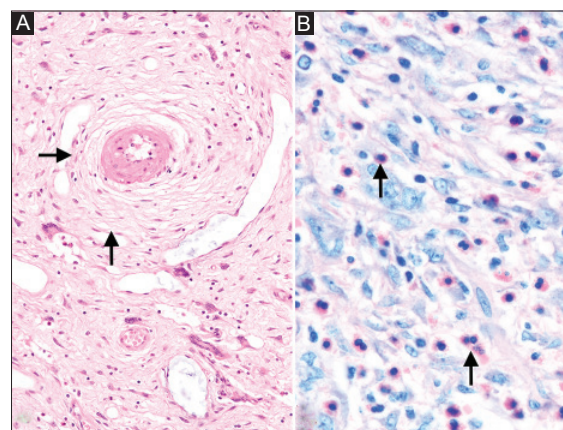


Figure 2 (A) Histology was compatible with a fibroid inflammatory polyp showing typical concentric onion-skin pattern of the stroma around vessels (arrows) (Hematoxylin-Eosin, 10x) (B) and marked eosinophilic infiltration (arrows) (Giemsa, 40x)

Departments of ^aGastroenterology, Site Notre Dame, Grand Hôpital de Charleroi, Charleroi (Georgios Mavrogenis, Milena Del Natale, Hocine Hassaini); ^bPathology, Institut de Pathologie et de Génétique, Gosselies (Michel Herin), Belgium

Conflict of Interest: None

Correspondence to: Georgios Mavrogenis, Department of Gastroenterology, Site Notre Dame, Grand Hôpital de Charleroi, 3 Grande Rue, 6000, Charleroi, Belgium, Tel.: +32 071102770, Fax: +32 071102779, e-mail: mavrogenis@gmail.com

Received 19 February 2016; accepted 24 February 2016; published online 17 March 2016

DOI: <http://dx.doi.org/10.20524/aog.2016.0026>

References

- 1 Ergun M, Zengin N, Kayacetin E. Loop observe and snare technique for endoscopic resection of a gastric inflammatory fibroid polyp. *Endoscopy* 2012;**44**(Suppl 2 UCTN):E86-E87.
- 2 Albuquerque A, Rios E, Carneiro F, Macedo G. Evaluation of clinicopathological features and *Helicobacter pylori* infection in gastric inflammatory fibroid polyps. *Virchows Arch* 2014;**465**:643-647.
- 3 Zinkiewicz K, Zgodzinski W, Dabrowski A, Szumilo J, Cwik G, Wallner G. Recurrent inflammatory fibroid polyp of cardia: a case report. *World J Gastroenterol* 2004;**10**:767-768.