

Case Report

Gastric adenomyoma: a case report

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Received: 10 February 2018

Accepted: 13 March 2018

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ABSTRACT

Upper gastrointestinal (GI) bleeding is usually seen secondary to esophageal varices or peptic ulcer disease, but at times, unusual causes can be encountered. We present one such case of a young 30-year-old gentleman who presented with recurrent episodes of upper GI bleeding secondary to gastric adenomyoma (GA), a rare, benign gastric tumor that usually remains asymptomatic or presents with vague abdominal symptoms.

Keywords: Antrum, Excision, Haemorrhage, Laparotomy, Submucosal tumor

INTRODUCTION

A wide spectrum of tumours is seen in the stomach - commonly, malignant tumours (adenocarcinoma) are encountered, but on occasion benign tumours (epithelial adenomas, lipoma, leiomyoma, etc.) may also be seen. Upper GI bleeding is far commoner in benign tumours such as leiomyomas than in cancers.

Gastric adenomyoma (GA) is a rare benign gastric submucosal hamartomatous tumour that is usually located in an antro-pyloric characteristically consisting of mixed - glandular, ductal as well as smooth muscle components. GA is usually asymptomatic, but at times, may present with non-specific gastrointestinal symptoms such as epigastric pain or vomiting and upper GI bleeding. To the best of our knowledge only 52 cases were reported till 2016.¹

CASE REPORT

A 30-year-old gentleman was admitted to our hospital with upper GI bleeding. There was no history of alcohol abuse, nausea, anorexia, diarrhoea, melena, or weight loss. There was similar episode 7 years back which had

subsided on its own. His clinical examination and laboratory parameters were normal. Upper GI endoscopy was performed, and it revealed a submucosal bulge along the greater curvature in the gastric antrum. The mucosa over the lesion was normal.

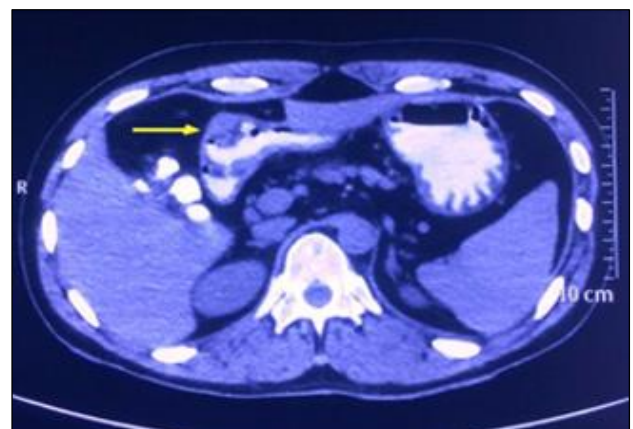


Figure 1: CECT scan.

The patient underwent abdominal computed tomography (CT) which showed a well-defined, intramural,

heterogeneous mass lesion in the gastric body along the greater curvature (Figure 1). There were no enlarged lymph nodes or distant metastasis and a diagnosis of gastric mesenchymal tumor, possibly leiomyoma was made, and the patient was prepared for surgery.

Laparotomy was performed by midline incision under general anaesthesia and the stomach was assessed. A firm, smooth, freely mobile, submucosal swelling was felt in the gastric antral wall, approximately 2 by 2 cm in size along the greater curvature. A wedge resection was performed to remove the tumour with a wide (2-3 cm margin) on either side; the gap in the stomach repaired in two layers using polygalactin 3-0. The patient remained well following surgery and was discharged in a satisfactory condition. He remains well on a follow up of almost 6 months.

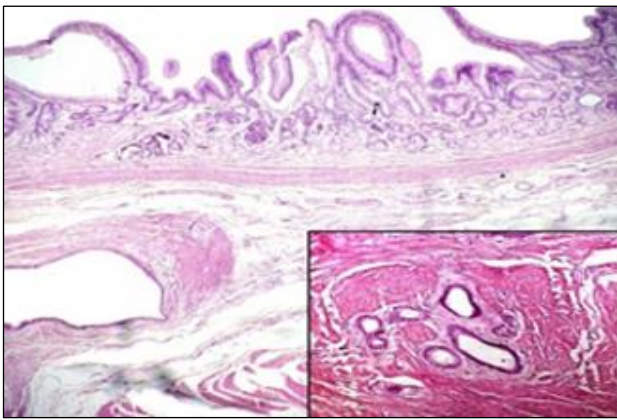


Figure 2: Histopathology.

The histopathology report revealed a submucosal grey white and firm tumor measuring $1.3 \times 1.2 \times 1.0$ cm. Sections from this showed a submucosal tumor composed of dilated ducts that were lined by cuboidal to columnar epithelium that were surrounded by interdigitating smooth muscle bundles (Figure 2), suggesting a diagnosis of gastric adenomyoma.

DISCUSSION

An adenomyoma is a lesion with both - epithelial as well as smooth muscle proliferation; although the gallbladder is the most frequent site for GI tract adenomyomas, a few cases have also been reported in the stomach, mainly in the antrum (85%).² Many authors have considered GA to be a hamartoma whereas others have suggested that it should be considered an abortive variant of heterotopic pancreas (HP), given its co-existence with HP as well as communication between the gastric lumen and the epithelial component of the lesion.^{3,4}

Despite its unclear etiology, GA remains a rare benign tumour that was first reported by Magnus-Alsleben in

1903.⁵ The most common location within the stomach is at the gastric antrum. GA can occur in any age group but is seen more commonly in the 4th to 6th decades.² Males are more commonly involved than females.⁶ Most patients are either asymptomatic or present with nonspecific gastrointestinal symptoms like epigastric pain and vomiting, making a preoperative diagnosis difficult. There are no classical radiological features to diagnose GA, and being submucosal in situation, even upper gastrointestinal endoscopic examination fails to provide representative tissue for histopathological confirmation. Contrast enhanced computerised tomography (CECT) is good for lesion localisation but the exact diagnosis can only be made by frozen section on table during surgery. The importance of frozen section lies in the fact that it should be differentiated from malignant adenocarcinomas to avoid extensive stomach resections as compared to only tumour resection in adenomyomas. Adequacy of surgical resection is determined by complete removal of the tumour; since it is a benign tumour, lymph nodes resection is not required, and gross total excision of the tumour is sufficient for treatment. Excision can also be done laparoscopically.⁷

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Bhardwaj S, Sinha S, Kundu R, Kaur R. Gastric adenomyoma: a case report. Int Surg J 2018;5:1587-8.