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Endoscopic Resection of a Large Pedunculated Gastric Gastrointestinal Stromal Tumour

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CLINICAL IMAGE

A 45-year-old woman without comorbidities presented with hematemesis 45 days prior. On examination, she was pale, and her systemic examination was unremarkable. Laboratory examination revealed iron-deficiency anemia. Upper gastrointestinal endoscopy revealed a large pedunculated polyp in the gastric fundus, measuring 5 cm, with a 1 cm vascular stalk (Figure 1A). Computed Tomography showed only a gastric polyp (Figure 1B). Endoscopic ultrasound (EUS) revealed a freely floating, isoechoic polyp with calcifications in the head region, without significant vascularity at the base, likely arising from the layer 2 of the gastric mucosa (Figure 1C and D). Hot snare polypectomy was performed after the application of an endoloop (Figure 1E-G). The postoperative period was uneventful, and the patient was discharged the following day. Histopathological and immunohistochemical examinations revealed a gastrointestinal stromal tumor with R0 resection (Figure 2A-C). She remains on follow-up without bleeding or recurrence. Calcification within gastric lesions is uncommon but is a valuable diagnostic indicator. The tumor location and calcification pattern help narrow the differential diagnosis.

Calcification can occur in subepithelial lesions, such as gastrointestinal stromal tumors, leiomyomas, and calcifying fibrous tumors, as well as in malignant conditions, such as mucinous adenocarcinoma.[1–3] Coarse or irregular calcifications tend to indicate stromal tumors, whereas punctate calcifications may indicate mucinous malignancies or vascular lesions. Dystrophic calcification is often observed in hyperplastic polyps. EUS

assessment should be performed before resecting large gastric pedunculated polyps (>1.5–2 cm) to assess stalk vascularity, echotexture, calcification pattern, and deeper invasion. Prophylactic endoloop placement in pedunculated polyps reduces post-polypectomy bleeding by occluding feeding vessels.[4,5] Guidelines recommend endoscopic resection as an alternative to laparoscopic wedge resection for gastric GISTs up to 35 mm in size protruding into the lumen.[6,7]

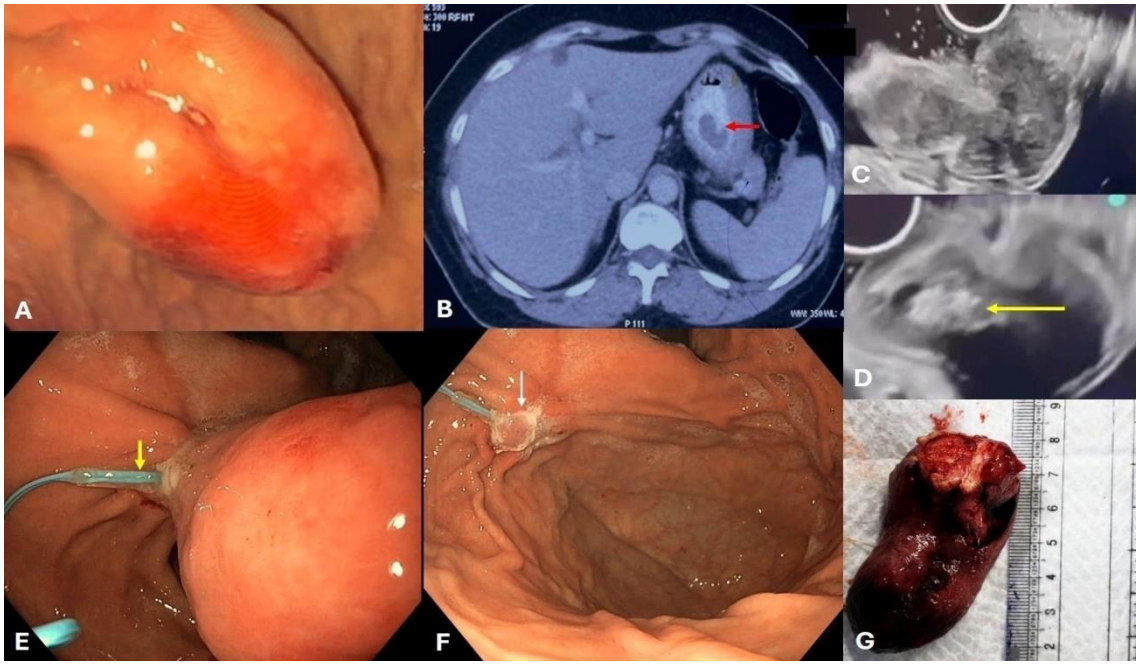

Figure 1: (A) Upper gastrointestinal endoscopy (UGIE) showing a large pedunculated gastric polyp arising from the gastric fundus. (B) Computed tomography showing a gastric polyp (red arrow). (C and D) Endoscopic ultrasound image showing a hyperechoic polyp with calcifications (yellow arrow in D) in the head region and without significant vascularity; the lesion likely originated from the second layer of the gastric wall. (E) UGIE image showing the application of a 30-mm endoloop at the base of the polyp (yellow arrow). (F) Site of hot snare polypectomy (white arrow) without significant bleeding, with the endoloop remaining in situ. (G) Gross specimen retrieved from the stomach, measuring 6 cm in length.

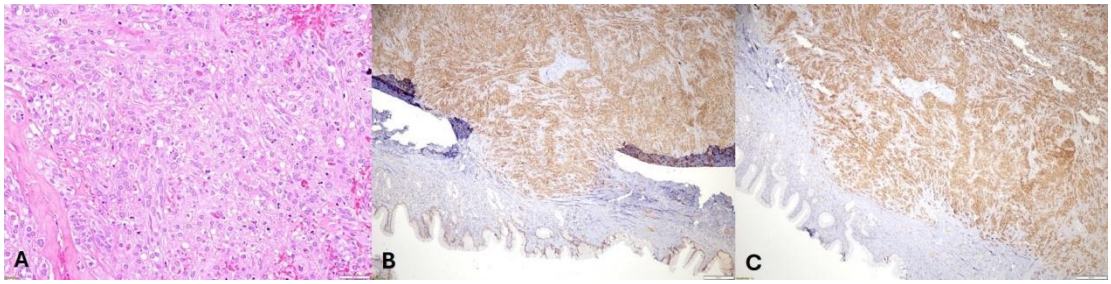

Figure 2: (A) Histopathology of gastric polyps showing round to oval tumor cells originating from the submucosa with a moderate amount of clear to pale eosinophilic cytoplasm, round nuclei with vesicular chromatin, and inconspicuous nucleoli. Mild nuclear pleomorphism was also observed. No necrosis was observed (H&E, 20x). The base of the polyp was free of tumors. Immunohistochemistry revealed strong diffuse positivity for DOG1 (B) and CD117 (C), suggesting a gastrointestinal stromal tumor.

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