Giant Inflammatory Fibroid Polyp of Stomach Causing Massive Upper Gastrointestinal Bleeding

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Abstract

A patient with a giant inflammatory fibroid polyp in the stomach presenting with massive upper gastrointestinal bleed is described.

Key Words: Stomach tumor

We report a patient with upper gastrointestinal (GI) tract bleeding caused by an inflammatory fibroid polyp in the stomach; this condition has hitherto not been described from India.

A 35-year-old housewife was referred with a complaint of six bouts of hematemesis (about 100 ml fresh blood and clots each time) in the preceding 24 h. During the previous 6 months she used to have mild post-prandial epigastric pain and fullness. There was no previous history of drug ingestion, anorexia, weight loss, vomiting, hematemesis or melena. Physical examination was normal except for pallor, tachycardia (100/min) and blood pressure of 100/80 mmHg.

Investigations: Hemoglobin 8.9 g/dl, WBC 6.4 × 10^9/L (polymorphs 93%), platelet count 225 × 10^9/L and normal coagulation profile and biochemical parameters.

The bleeding stopped temporarily with blood transfusion, antacids and parenteral pantoline. On the second day, endoscopic examination revealed an 8 cm × 10 cm sessile nodular growth along the lesser curve just below the gastro-esophageal junction. Fresh oozing was noticed from multiple sites on the surface of the growth. The rest of the stomach and duodenum was normal. Histological examination of the endoscopic biopsy specimens from the surface and edges of the growth was inconclusive. During the next 3 days, the patient had repeated episodes of upper GI bleeding requiring transfusion of 20 units of whole blood. At laparotomy, a 10 cm × 10 cm sessile, nodular growth was seen on the lesser curve just below the gastro-esophageal junction. Its surface was reddish brown and ulcerated. Perigastric lymph nodes were not enlarged and the liver was normal. Since the growth appeared malignant, the proximal two-thirds of the stomach and the lower 5 cm of the esophagus (Fig) were resected, followed by anastomosis of the remaining esophagus with the distal stomach. Post-operatively the patient was put on a ventilator for poor respiratory effort; she died on the second post-operative day.

Pathological findings: Cut section showed a greyish white appearance and the growth seemed to extend partially into the muscle layer. The mucosa of the body of the stomach showed multiple superficial (stress) hemorrhagic ulcers, 0.3 cm to 1 cm in diameter. Microscopic examination of the growth showed loose connective tissue stroma with many blood vessels ranging from thin walled capillaries to veins and larger vessels. There was diffuse infiltration by lymphocytes, plasma cells, neutrophils and many eosinophils. The growth was situated in the submucosa, partially invading the muscle layer. The pathological diagnosis was giant inflammatory fibroid polyp of the stomach.

Fig: Resected stomach specimen cut open along the greater curve. The polyp occupies the center of the specimen (arrows).

The commonest site of a gastric inflammatory fibroid polyp is the prepyloric region. The macroscopic appearance is either a sessile or more commonly a polypoidal mass. Most patients present with nonspecific abdominal complaints; a few may present with features of gastric outlet obstruction due to the polyp prolapsing into the pylorus. Massive upper GI bleed has been reported only once; anemia due to chronic blood loss is more common.1 While endoscopic polypectomy may correctly diagnose the lesion, endoscopic biopsies alone are likely to be fallacious in about half the cases. In one study,2 the diagnosis was changed after polypectomy in five of 12 suspected cases of inflammatory fibroid polyps. The diagnostic difficulty is greater with sessile polyps (as in our case). Frozen section of the polyp during laparotomy may help to exclude malignancy and prevent radical surgery for this benign disease.
There are no reports of malignant transformation in these polyps.2

Our case was unique because of unusually large size (9 cm), atypical location (just below the cardia) and presentation with massive upper GI bleed; early surgery might have prevented her death.

References