Gastric antral lipoma presenting as gastric outlet obstruction

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A 52-year-old male presented with upper abdominal pain and intermittent vomiting of a year's duration. Physical examination and clinical chemistry were normal. Upper gastrointestinal endoscopy revealed a submucosal lesion in the pyloroantral region with normal overlying mucosa. Contrast-enhanced computed tomography (CECT) scan of the abdomen (Fig. 1) showed an intramural lesion with low attenuation in the pyloroantral region with obstruction. Endoscopic ultrasound-guided fine-needle aspiration

Fig. 1 CECT of the abdomen showing a 3 cm × 2.5 cm × 1.5 cm (arrow) low-attenuation (−89 Hounsfield units) lesion in the pyloroantral region with mild proximal gastric dilatation

Fig. 2 Surgical specimen showing the submucosal lesion (thick arrow) and the proximal resection margin (thin arrow)

cytology revealed a well-defined hyperechoic submucosal lesion composed of adipose tissue. A limited resection with gastroduodenostomy was done. The operative specimen showed a submucosal lipoma (Fig. 2). Gastric lipomas accounts for 3 % of all benign tumors of the stomach. They are usually asymptomatic but may present with gastric outlet obstruction, hematemesis, or iron deficiency anemia [1, 2]. CECT is diagnostic because of the low attenuation factor but does not differentiate liposarcoma.

References

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