



Imaging findings of an isolated gastric tuberculosis case mimicking lymphoma and infiltrative gastric cancer

To the Editor,

Gastric tuberculosis is an uncommon disease and occurs as a primary or secondary condition (1). Gastric tuberculosis patients usually have concurrent pulmonary tuberculosis or an immune system deficiency (1-3), and as a result, it is particularly difficult to clinically and radiologically diagnose cases of isolated gastric tuberculosis (1-5). In this report, we present the clinical and radiological features of an immunocompetent patient with gastric tuberculosis, who was hospitalized for abdominal discomfort without involvement of any other system and with radiologic findings mimicking an infiltrative gastric tumor or lymphoma. Written informed consent was obtained from patient who participated in this case.

A 23-year-old woman was admitted to our hospital because of abdominal pain since 4 weeks that became

intermittently more acute in the epigastric region. She also reported vomiting after every meal and had lost 5 kg of weight. She did not report cough, dyspnea, or hemoptysis. She had no family history of tuberculosis or known systemic disorder. On physical examination, the patient appeared pale and cachectic. The C-reactive protein (CRP) concentration and erythrocyte sedimentation rate were mildly elevated above their normal ranges. Plain chest radiographs were normal. On ultrasonography, the gastric wall was diffusely, symmetrically, and significantly thickened, and was hypoechoic with a pseudokidney appearance. Abdominal computed tomography (CT) was performed to evaluate the stomach and other abdominal organs. The dynamic contrast-enhanced CT scan revealed circumferential thickening of the entire wall of the corpus and antrum of the stomach (Figure 1). The external gastric contours were quite smooth. Increased densities were detected

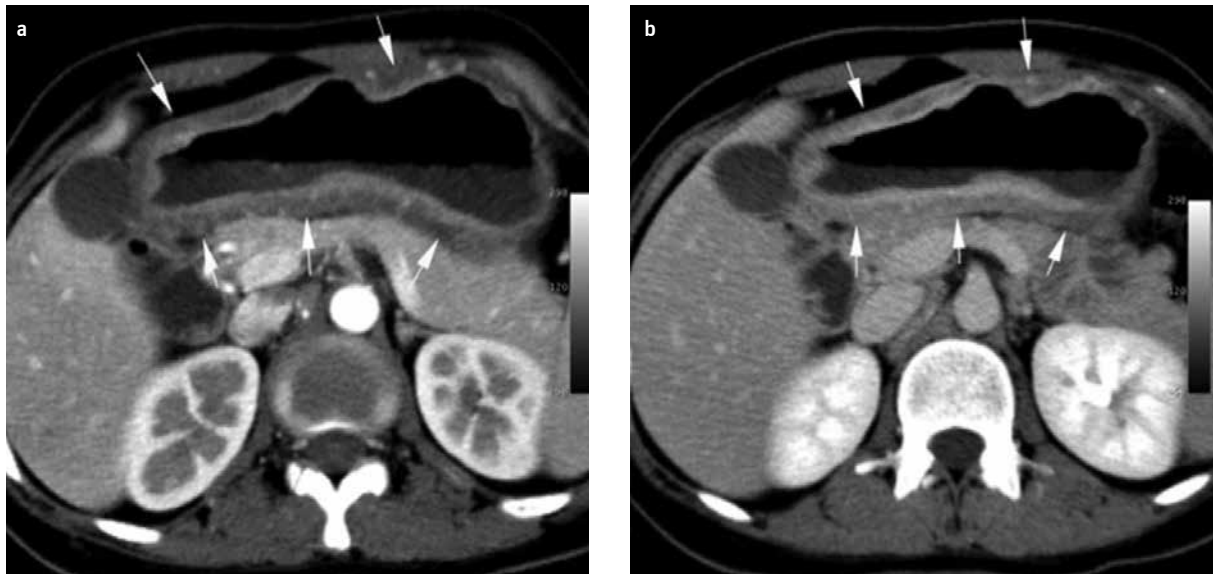


Figure 1. a, b. Axial contrast-enhanced abdominal CT of 23-year-old woman. Diffuse gastric wall thickening with smooth outer contours were observed in the corpus and antrum during the arterial phase (a). The venous phase showed increased contrast enhancement of the gastric wall (b).

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Figure 2. a, b. Enlarged lymph nodes were identified adjacent to the gastric cardia (**a**) and within the gastrocolic ligament (**b**).

in the fat tissue surrounding the stomach and in the gastrocolic ligament. The lymph nodes adjacent to the gastric cardia and antrum, and within the celiac group and gastrocolic ligament were enlarged as well (Figure 2). An endoscopic biopsy was performed, and the histopathologic examination of the gastric specimens was consistent with granulomatous gastritis characterized by a dense population of abortive granulomas, regeneration, and inflammation. Because the initial endoscopic findings suggested a gastric tumor, the endoscopic biopsy procedure was repeated. The histopathological examination of the second biopsy specimens revealed epithelioid granulomas and granulomas comprising Langhans-type giant cells with caseous necrosis in some granulomas. Therefore, the patient was diagnosed with gastric tuberculosis and administered anti-tuberculosis treatment.

Isolated gastric tuberculosis is particularly challenging to diagnose clinically and radiologically; therefore, endoscopy is important for an accurate diagnosis. The radiological appearance may be misidentified as gastric lymphoma or a diffuse infiltrative tumor. In the differential diagnosis of diffuse infiltrative lesions in the stomach, gastric tuberculosis should also be considered.

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