Inflammatary myofibroblastic tumour of the gall bladder: A rare case report.

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INTRODUCTION

- Inflammatory myofibroblastic tumour is a rare mesenchymal neoplasm composed of myofibroblastic and fibroblastic spindle cells without nuclear atypia accompanied by an inflammatory infiltrate of plasma cells, histiocytes, and eosinophils.  
- Inflammatory myofibroblastic tumour was first observed in lungs and described by Bunn in 1939.  
- It was named as Inflammatory myofibroblastic tumours by Umiker et al. because it mimics malignant neoplasm clinically and histopathologically.  
- Inflammatory myofibroblastic tumours are rare benign tumours that can mimic malignancy, also known as inflammatory pseudotumours, cellular inflammatory pseudotumours and plasma cell granulomas.  
- Their etiology is not clearly understood.  
- Inflammatory myofibroblastic tumours primarily affects children and young adults with slight female predominance.  
- Lung, liver and gastrointestinal tract are most common site of involvement.  
- The commonest site reported in the biliary tree is extra hepatic bile duct. Gall bladder is a rare site of Inflammatory myofibroblastic tumours.

CASE REPORT

- A 36 years old female presented with complaint of flatulence and dyspepsia in surgery out patient department.  
- On examination general condition of the patient was good.  
- Per abdominal examination was unremarkable except an old infraumbilical vertical laparotomy scar.  
- Laboratory tests revealed leukocytosis, increased erythrocyte sedimentation rate and hypergammaglobulinemia.  
- Provisional clinical diagnosis was cholelithiasis with gastroesophageal reflux disease.  
- Ultrasoundography revealed contracted gall bladder with few calculi.  
- Contrast enhanced computed tomography abdomen and pelvis shows diffuse gall bladder wall thickening with hepatic infiltration and mass abutting into duodenum and pylorus. Significant lymphadenopathy including small node at porta hepatis seen.  
- Radiologically carcinoma gall bladder was suspected.  
- Extended cholecystectomy with Billroth II anastomosis was performed.  
- Intraoperatively gall bladder was fibrosed, contracted with an impacted stone and a mass infiltrating into liver, pylorus and first part of duodenum.

GROSS AND MICROSCOPY

Gross: Gall bladder was dilated measuring 4x2.5cm. On cutting open, an impacted stone in lumen seen. Gall bladder wall was thickened ranging from 0.3 to 0.5 cm. Serosal aspect of gall bladder showed presence of solid nodular area involved up to the pyloric end of the stomach. An attached liver tissue was also identified.

Microscopy: Section from gall bladder revealed thickened fibrotic wall, presence of papillaroid structure with ulcerated lining epithelium and features of chronic cholecystitis.  
- Gall bladder wall showed proliferated and congested blood vessels with dense infiltration of mixed inflammatory infiltrate predominantly lymphoplasmacytic, fair number of eosinophils, hypertrophied muscle bundles, proliferated myofibroblasts and giant cells.  
- Similar finding extending up to the pyloric end of stomach as well as to attached liver was seen.  
- Pathological diagnosis of inflammatory myofibroblastic tumour of gall bladder with involvement of liver bed, resected end of pylorus and duodenum was given.

CONCLUSION

- Inflammatory myofibroblastic tumours of the gallbladder is a rare benign mesenchymal tumour which can be localized in the gall bladder mimicking gall bladder cancer, so it should be considered in the differential diagnosis of a gallbladder mass.  
- It is important to acknowledge inflammatory myofibroblastic tumour of gall bladder, so that patient will not be unnecessarily subjected to debulking surgery and chemotherapy.

REFERENCES