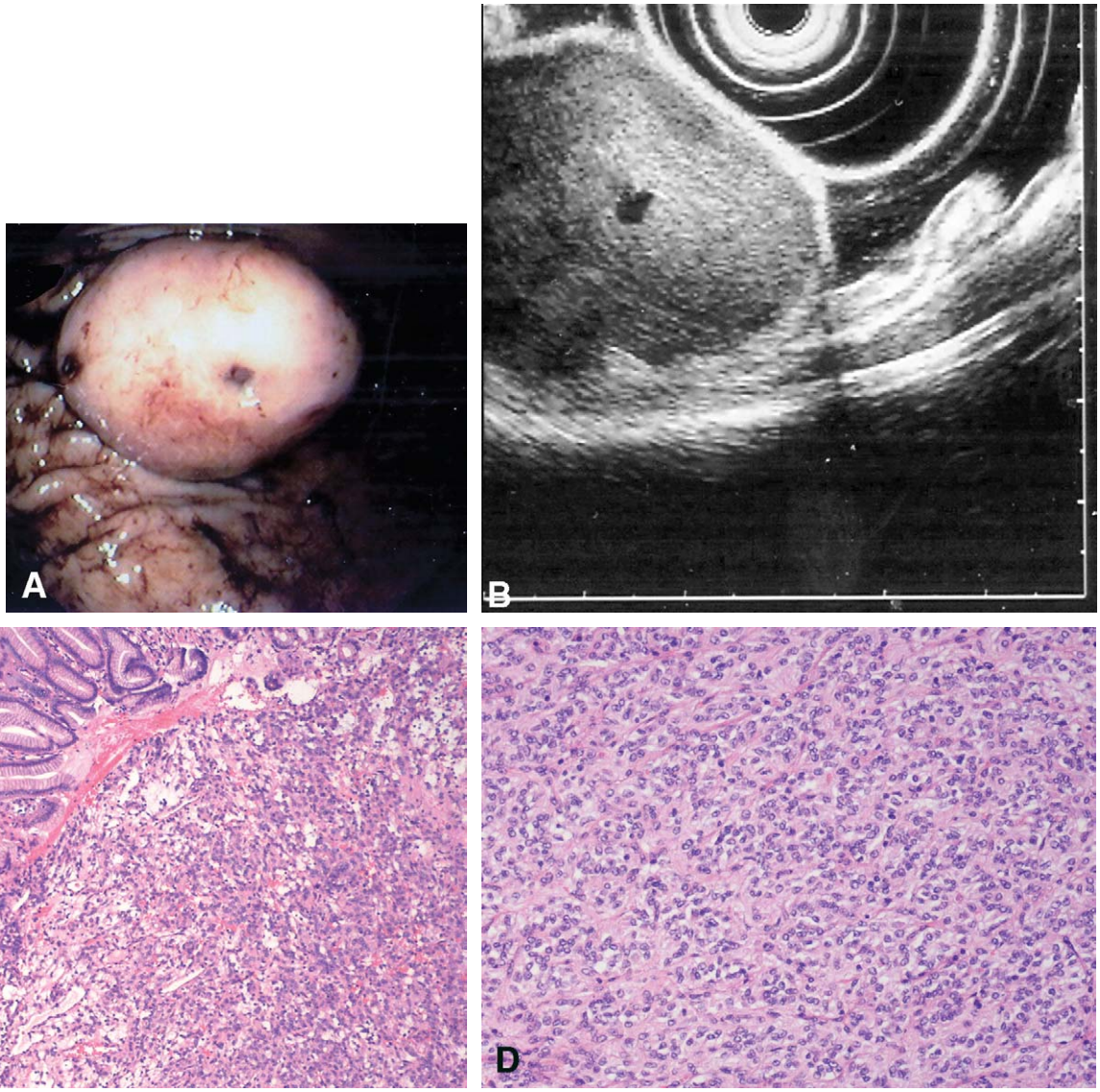
GIANT BLEEDING STROMAL TUMOR



A 42-year-old woman presented to the emergency department with massive hematemesis. The medical history was unremarkable. Examination revealed pallor, a systolic blood pressure of 90 mm Hg, and a pulse of 138 beats per minute. The Hb was 6.3 g/dL (normal: 12-14.5 g/dL) and hematocrit 22.7% (38%-42%). After hemodynamic resuscitation by volume repletion and transfusion of 4 units of packed red blood cells, endoscopy demonstrated a giant polypoid submucosal lesion in the mid body of the stomach. There were multiple ulcers over the lesion, one of which contained a fresh clot (**A**). This ulcer was injected with 4 mL of a 1:10,000 solution of epinephrine. EUS the next day revealed a 6.8 × 4.4-cm hypoechoic mass arising from the fourth sonographic layer. It had a homogeneous echo pattern and regular extraluminal margins (**B**). The tumor was surgically resected. Histopathologic evaluation revealed an ulcerated tumor (**C**; H&E, orig. mag. ×100) that was composed of a proliferation of round cells with variable eosinophilic to clear cytoplasm (**D**; H&E, orig. mag. ×200), findings

consistent with a diagnosis of epithelioid-type GI stromal tumor. Mitotic activity was negligible (<5/50 high power field). The postoperative course was uneventful, and there has been no further bleeding.

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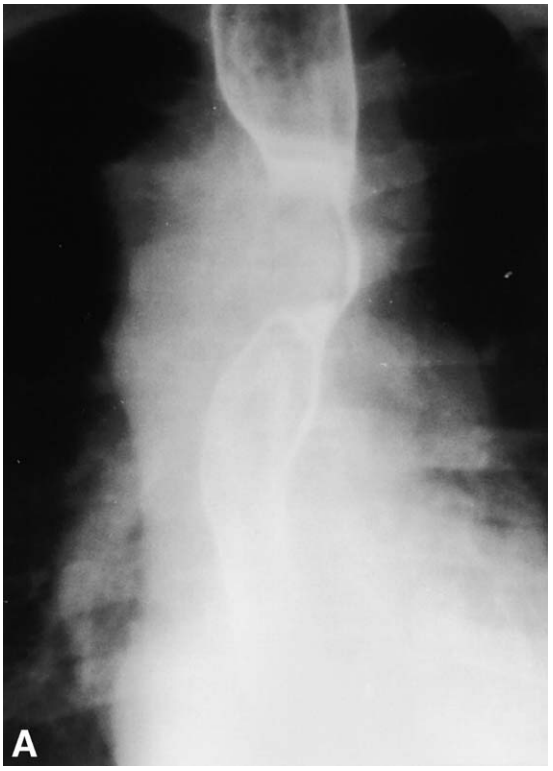
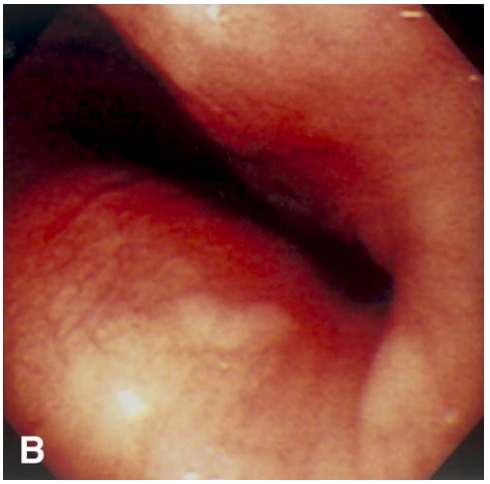
RIGHT-SIDED AORTA WITH KOMMERELL'S DIVERTICULUM





A 49-year-old man was referred for evaluation of an extrinsic compression of the esophagus that was discovered incidentally when an EGD was performed as part of a routine health examination. There was a 30-year history of mild dysphagia that mainly occurred when the patient consumed large meals. Vital signs were normal, and examination was unremarkable. A blood count and standard biochemical tests were within normal ranges. A chest radiograph demonstrated a right-sided aortic arch, and barium contrast radiography revealed extrinsic compression of the proximal esophagus (**A**). At endoscopy, external compression of the esophagus was evident at 27 cm from the incisor teeth (**B**). In addition to demonstrating the right-sided aortic arch, radial scanning EUS also disclosed a diverticular structure adjacent to the arch at the level of the extrinsic compression of the esophagus (**C**). A dilated esophagus with an air-fluid level was noted on magnetic resonance imaging, and magnetic resonance angiography (**D**) confirmed the diagnosis of right-sided aortic arch