Waldum et al.² suggest that the diffuse form of gastric carcinoma may be derived from ECL cells. They propose that the occasional mixed tumours seen in the stomach,³ of which this is the equivalent in the oesophagus, could occur by proliferation of a more primitive cell than the committed ECL cell or be the result of paracrine effects of mediators released by the endocrine cells themselves. This raises the possibility that ECL cells could be important in the origin of other oesophageal adenocarcinomas. This is of particular relevance in Barrett’s oesophagus as omeprazole is a standard therapy for this condition and long term treatment with this drug causes ECL hyperplasia and development of carcinoid tumours in rats.¹⁰

went further resection of the remaining lung. At thoracotomy a hard irregular mass was palpated in the posterior aspect of the right lower lobe. Macroscopically the lesion consisted of grey elastic tissue which microscopically proved to be a suture granuloma (fig 2). No signs of malignancy were found in the resected lung. The postoperative course was complicated by a bronchopleural fistula which closed with conservative treatment and since then the patient has been well.

Discussion
Suture granulomas are quite common after surgical procedures such as splenectomy, gastrectomy, colectomy, herniorrhaphy, prostatectomy, cholecystectomy, brain surgery, and bladder surgery.1-9 The occurrence of a suture granuloma mimicking a tumour in the lung is very rare. Reviewing the literature we found only one case mentioned which followed resection of metastatic nodules in the lung from a synovial sarcoma.10

In this case several points may be emphasised. The shape of the lesion on the computed tomographic scan which consisted of a spiculated mass (fig 1) was typical for malignancy and was misleading. The speed with which the lesion developed after surgery, however, should have suggested the possibility of a benign process and a suture granuloma should have been considered. This could have been confirmed by a fine needle aspiration before surgery or by frozen sections at thoracotomy.

The rarity of this complication in the lung compared with the development of tumour recurrence after segmental resection would make the differentiation between the two quite challenging. Our experience should encourage clinicians to pursue the diagnosis and not rush into unnecessary resection.

Figure 1 Computed tomographic scan three months after the second thoracotomy showing a 2 cm lesion with irregular spiculated borders in the posterior segment of the right lower lobe.

Figure 2 Micrograph showing fragments of suture material surrounded by hard connective tissue, giant cells, and mild chronic inflammatory reaction.