Leiomyosarcoma of the third part of the duodenum that presented with perforation. [Indian J Gastroenterol 2001;20:30-31]

Key words: Duodenal tumor

Leiomyosarcoma of the duodenum is rare. It occurs in the second part of the duodenum and presents with bleeding or pain.1 We report a patient with duodenal leiomyosarcoma occurring in the third part of the duodenum, who presented with perforative peritonitis.

A 45-year-old woman presented with history of acute abdominal pain of 3 days' duration. There was no significant previous history. The pulse rate was 140/min, respiratory rate 32/min, and systolic blood pressure 90 mmHg. The abdomen was guarded and rebound tenderness was present. Plain radiographs did not reveal free gas under the diaphragm. Ultrasonography revealed free fluid in the peritoneal cavity; CT scan showed retroperitoneal and mesenteric inflammation, in addition to free fluid, with normal pancreas. Sero-purulent fluid, aspirated on abdominal paracentesis, showed presence of Gram-negative organisms.

At exploratory laparotomy, the stomach, first two parts of the duodenum, and the rest of the small bowel were normal. There was 500 mL of sero-purulent fluid in the peritoneal cavity. The retroperitoneum was edematous and showed presence of gas; the pancreas was normal. After extensive Kocherization, a large perforation, 1 cm x 2 cm, was seen on the posterior surface of the third part of the duodenum. Palpation revealed a hard mass not involving the serosa, with its distal margin extending into the fourth part of the duodenum. Digital palpation through the perforation revealed complete luminal obstruction by the mass. Multiple mucosal biopsies were taken through the perforation. Resectional surgery was deferred in view of poor general condition of the patient and local sepsis. Diversion was achieved with a T tube, which was inserted through the perforation. A feeding jejunostomy was added. The patient died on the third postoperative day due to septicemia. Histology of the mass revealed epithelioid leiomyosarcoma with spindle-shaped cells and occasional mitosis (Fig).

Leiomyosarcomas of the duodenum are rare, representing only 8%-22% of small bowel malignancies.1 They commonly occur in the second part of the duodenum. The growth is usually extrinsic or suberosal. Common presenting symptoms are abdominal pain, weight loss and bleed.2 We did not find in literature a report of duodenal leiomyosarcoma presenting with perforation. Presentation is usually delayed due to late involvement of the mucosa. Endoscopy and CT scan are useful in diagnosis. Small intestinal barium study3 and modified duodenography4 may also be useful. Surgical treatment by duodenopancreatojejunostomy is usually curative for neoplasms in the third part of the duodenum.2

The prognosis of duodenal neoplasms is poor because of delayed symptoms, especially in patients presenting with weight loss or obstructing symptoms.5

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Ganglioneuroma of small intestine presenting with perforation peritonitis

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We report a 42-year-old man with benign solitary small intestinal ganglioneuroma presenting with perforation peritonitis. The patient had no evidence of MEN 1B syndrome. Simple segmental resection was done; the patient is well on follow up one year later. [Indian J Gastroenterol 2001;20:31-32]

Key words: Small intestine tumor

Small bowel tumors constitute only 3% to 6% of gastrointestinal tract tumors.1,2 Most of them are found incidentally at operation or at autopsy. Benign tumors may present with pain secondary to intussusception and intermittent incomplete obstruction.

A 42-year-old man presented with diffuse pain in the abdomen and constipation for 2 days, along with fever for five

Fig: Epithelioid leiomyosarcoma showing spindle-shaped cells with occasional mitosis (H&E, 100X)
days. He had no similar complaints in the past. On examination, the patient had signs suggestive of diffuse peritonitis. Plain erect abdominal radiograph revealed no pneumoperitoneum.

At laparotomy, about 400 mL of pus was found in the pelvic cavity and right paracolic gutter. An 8 cm x 6 cm tumor was found in the small bowel about 50 cm from the ileocolic junction, adherent to pelvic organs, with 1 cm perforation of the tumor. The tumor was resected along with 10 cm of adjacent ileum, end-to-end anastomosis was carried out in two layers, and peritoneal lavage was given. The postoperative period was uneventful except for wound infection, which was treated with daily dressings and secondary suturing.

Histology of the mass revealed spindle to elongated cells with oval nuclei, arranged in the form of interwoven and criss-cross bundles (Fig.). Immature ganglion cells were seen between the fascicul. A diagnosis of ganglioneuroma of the ileum was made. The patient is doing well one year later.

The most common presentation of benign small bowel tumors is pain due to partial obstruction; occult bleeding is the second most common symptom.1,3 Presentation with perforation peritonitis has not been described earlier. The most common small bowel benign tumor is leiomyoma, followed by adenoma, lipoma and hemangiom.a Benign neurogenic tumors of the small intestine are rare. Ganglioneuromas are benign tumors originating from the sympathetic chain and are composed of ganglion cells and nerve cells. They typically present at an early age and are the most common neurogenic tumors during childhood. Ganglioneuromas commonly occur in the retroperitoneum, neck and mediastinum.

Ganglioneuromas are usually a part of the MEN IIB syndrome where they may be diffuse or polyoidal. Polyoidal ganglioneuromatosis have also been described with juvenile polyposis, Cowden’s syndrome, multiple adenomas and colorectal carcinomas.

Treatment for isolated lesions is resection and anastomosis. For multiple ganglioneuromatosis, resection of the involved part along with the mesentery has been reported. Follow up for MEN IIB syndrome is needed.4

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Laparoscopic cholecystectomy in patient with portal cavernoma and portal hypertension

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Successful laparoscopic cholecystectomy has been reported in patients with cirrhosis of liver with portal hypertension; the procedure has, however, not been reported in patients with portal vein thrombosis, portal cavernoma and portal hypertension. We report an 18-year-old man with portal hypertension due to portal vein thrombosis and portal cavernoma who had symptomatic gallstone disease and was successfully treated with laparoscopic cholecystectomy. [Indian J Gastroenterol 2001;20:32-33]

Key words: Portal vein thrombosis

Cirrhosis and portal hypertension are considered as contraindications to laparoscopic cholecystectomy,1 because of the fear of bleeding. Portal hypertension due to portal vein thrombosis and portal cavernoma formation is associated with numerous vessels in and around the porta hepatitis, Calot’s triangle, gall bladder and gall bladder fossa. We found no report of laparoscopic cholecystectomy being performed successfully in patients with portal cavernoma and portal hypertension, though the procedure has been reported in cirrhosis and portal hypertension.1,2

An 18-year-old man was referred with a diagnosis of extrahepatic portal venous obstruction and symptomatic gallstones. There was a history of viral hepatitis 6 months back. On examination, he had no icterus. Abdominal examination revealed splenomegaly.

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