patient was kept nil orally, with intravenous drip infusion.

Laboratory tests revealed white cell count of 13,600/mm³ and C-reactive protein 30.9 mg/dL. He was started on antibiotic, and fever, abdominal pain and symptoms of ileus were alleviated. Three weeks later, CT revealed that the tumor had shrunk to 4 cm in diameter. Middle colic artery angiography revealed a hypervascular tumor. Gastrosopic, colonoscopy, imaging of the small intestine and barium enema showed no abnormality. Seven months later, since the tumor remained 4 cm in size on imaging, it was removed surgically. The tumor originated in the transverse colon mesentery and involved the surrounding omentum. It adhered tightly to the jejunal mesentery and also infiltrated the jejunum. The tumor was removed, and the transverse colon and jejunum were partially resected.

The excised tumor was a grayish-white, solid mass. Histologically, it showed well-differentiated spindle-shaped fibroblasts. No heteromorphism was found, and mitosis was rare. It was diagnosed as desmoid tumor derived from the transverse colon mesentery. No recurrence was observed 1 year later.

Retiano et al. reported that the incidence of desmoid tumor was 2-4 cases per one million population, and intra-abdominal desmoid tumors accounted for 8% of these. In most cases, the tumor occurred as a complication of familial adenomatous polyposis, or the patients had a past history of abdominal operation or estrogen therapy. Our patient had no such history. Though desmoid tumor derived from the mesentery has been reported to spread in the abdominal cavity after operation, the tumor is benign and shows gradual growth.

Our patient had symptoms of acute abdomen and the tumor size decreased rapidly with remission of inflammation on medical treatment. Penetration of the tumor into the jejunum or part of the transverse colon was suspected, though imaging and endoscopy of the digestive tract showed no change. Infiltration of the gut by abdominal desmoid usually does not reach the mucosa; penetration of the digestive tract, as observed in our patient, is very rare.

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Correspondence to: Dr. Habib, Third Department of Internal Medicine, Osaka City University Medical School, 1-4-3 Asahimachi, Abeno-ku, Osaka 554 8585, Japan. Fax: 81 (6) 8645 3813. E-mail: dahl@med.osaka-cu.ac.jp
Received January 24, 2002. Accepted February 24, 2002

Extraperitoneal pedunculated leiomyoma of stomach

MEREDZAN P KATRAK, N N MEHTA, A S SINHA, P S PATNAIK, A S KHITHAN, RAJEEV M JOSHI

Department of Surgery, B Y L Nair Charitable Hospital and T N Medical College, Mumbai 400 008

Leiomyoma of the stomach, a type of gastrointestinal stromal tumor, is uncommon. We report a 51-year-old woman with an extraperitoneal pedunculated leiomyoma of the stomach. [Indian J Gastroenterol 2002;21:200-201]

Key words: Gastrointestinal stromal tumor

Leiomyomas are benign tumors that are classified as gastrointestinal stromal tumors (GIST) as they arise from mesenchymal tissue. GIST account for 1% of all gastrointestinal tumors and most occur in patients above 40 years of age. The stomach is involved in 60%-70% of cases and small intestine in 30%.

A 51-year-old woman was admitted with complaints of dull aching pain in the epigastic region, nonradiating and unrelated to meals, since one year. Abdominal examination was normal. All hematological and biochemical parameters and upper GI endoscopy were normal. Ultrasonography showed an isoechogenic mass, 5.4 cm x 3.5 cm, posterior to the stomach in the region of the head of the pancreas but separate from it. CT scan showed a lobulated mass posterior-inferior to the greater curvature of the stomach with well-maintained surrounding fat planes, suggestive of subserosal leiomyoma or desmoid tumor. Endosopic ultrasonography (EUS) showed a large mass of heterogeneous echotexture, appearing to arise from the muscularis propria in the greater curvature and anterior wall of the stomach, suggesting a subserosal leiomyoma (Fig). EUS-guided FNAC yielded a few spindle-shaped cells.

On exploration, a pedunculated mass, 6 cm x 4 cm x 3 cm, was seen arising from the greater curvature in the antral portion of the stomach and lying in the lesser sac. The tumor was mobile and had a very thin pedicle connected to the stomach. Local excision of the tumor and a part of the stomach wall was performed using a stapler. The postoperative course was uneventful. Histology showed a tumor consisting of spindle cells arranged in fascicular and interfacing bundles. Section from the pedicle showed muscle layer and the tumor appearing to arise from it. There was no abnormal mitosis. The diagnosis was GIST – leiomyoma with no evidence of malignancy.

The patient is asymptomatic four months later.

Most gastric leiomyomas are submucosal and may present with bleeding due to erosion of the covering mucosa. Large leiomyomas may present as a lump or
Large Brunneroma presenting with bleeding

GAJANAN D WAGHOLIKAR, SADHANA DHINGRA,*
NARENDRA KRISHNANI,* VINAY K KAPOOR

Departments of Surgical Gastroenterology and
*Pathology, Sanjay Gandhi Postgraduate Institute of
Medical Sciences, Raebareli Road, Lucknow 226 014

Brunner's gland adenoma (Brunneroma) is a rare entity. We report a patient who presented with severe anemia due to bleeding from a large Brunneroma arising from the duodenal bulb, and was managed successfully by surgical excision of the tumor. [Indian J Gastroenterol 2002;21:201-202]

Key words: Brunner's gland hyperplasia, duodenal polyp

Brunner's gland adenoma (Brunneroma) is a rare entity. We report a patient who presented with severe anemia due to bleeding from the tumor.

A 38-year-old man presented with a 3-month history of intermittent episodes of melena. There was no history of hematemesis or any history suggestive of acid-peptic disease, portal hypertension or intake of NSAID. There were no significant findings on clinical examination apart from severe pallor. Laboratory investigations revealed severe anemia with hemoglobin of 6 g/dL and hematocrit of 20%. Other hematological and biochemical investigations were within normal limits. Upper gastrointestinal endoscopy revealed a large polyp in the duodenal bulb projecting into the second part of the duodenum with hyperemic and friable overlying mucosa. As the stalk was quite broad, endoscopic polypectomy was not possible.

At surgery, after preoperative transfusion of two units of blood, there was a large polyoid lesion arising from the duodenal bulb and extending into the second part of the duodenum. After Kocherizing the duodenum an inferior duodenotomy was made over the superior duodenal flexure and a large reddish brown polyp, 5 cm x 4 cm in size with a 2 cm wide stalk, was delivered out. Excision was done after transfixing the base and duodenotomy closed in two layers. A nasojugal tube was placed at surgery to initiate early enteral alimentation. The postoperative period was uneventful. Histology of the resected polyp showed Brunner's gland adenoma (Fig).

Brunner's glands are aciniform tubuloalveolar mucus-secreting glands in the submucosa of the duodenum. These glands are more numerous in the juxtapyloric part of the duodenum; distally they decrease in size and number until they disappear around the duodeno-jejunal flexure. Their alkaline secretion buffers the acidic gastric contents entering the duodenum. Recently they have been shown to secrete the polypeptide hormone urogastrone which

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