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ENORMOUS ABDOMINAL TUMOR

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ABSTRACT

Introduction: Digestive stromal tumors are mesenchymal tumors developed from Cajal cells. Gastric localization is the most frequent. Extra-digestive and especially mesenteric forms are more rare: less than 5% of all digestive stromal tumors. **Patients and methods:** 27 years-old, admitted to the service following the appearance of an abdominal mass progressively increasing in volume, occupying the whole abdomen about 28 cm long. **Results:** operated by a median laparotomy ,an enormous mass occupying the entire abdominal frame at the expense of the mesentery was removed. the anatomopathological report concluded on a enormous stromal mass of the mesentere. The immuno-histochemical study showed expression for CD117 and CD34. The patient was treated with imatinib (Glivec) for six months with good tolerance. There was no evidence of recurrence on a five-year of the follow-up. **Conclusion:** Rare tumor revealed by an enormous mass occupying all the belly,we report a case of giant stromal tumor of the mesentery colligead in the general surgery service.

KEYWORDS: Gastrointestinal stromal tumors,C-kit,Cells of Cajal,STI 571,Diagnosis and Treatment.

OBSERVATION

Male patient 27 years-old, without surgical and medical history, admitted to the service following the appearance of an abdominal mass progressively increasing in volume, evolving in an apyretic context with conservation of the general state.

Legendes

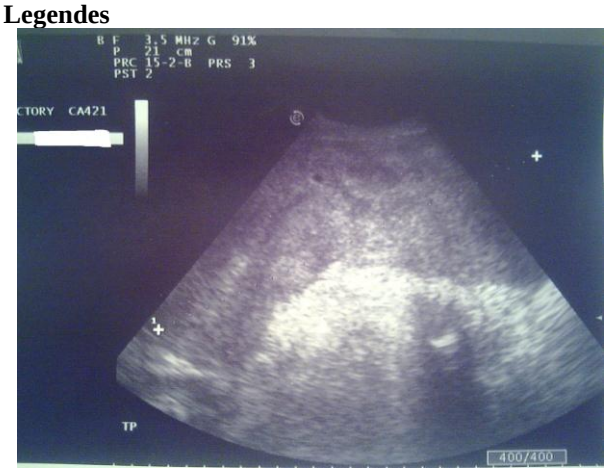

Figure 1: abdominal US showing avoluminous abdominopelvic mass.

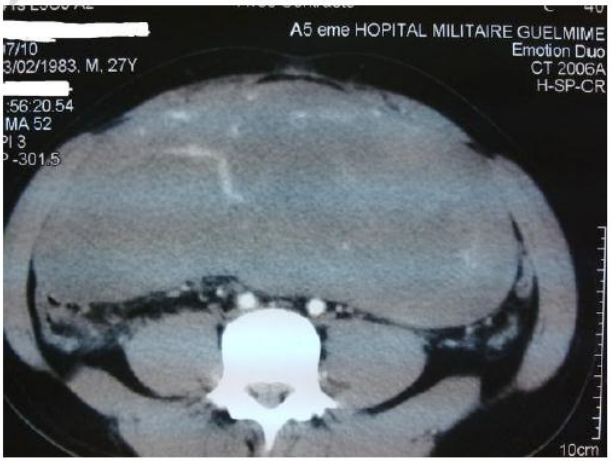

Figure 2: CT showing a tumor of heterogeneous density measuring 32X30X7Cm.

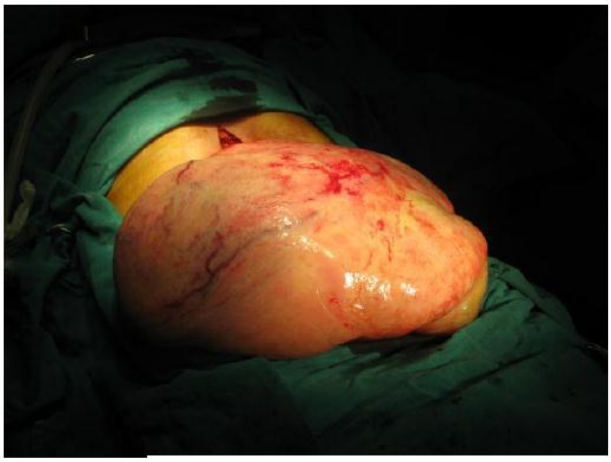

Figure 3: Operative view of this voluminous abdominopelvic tumor.

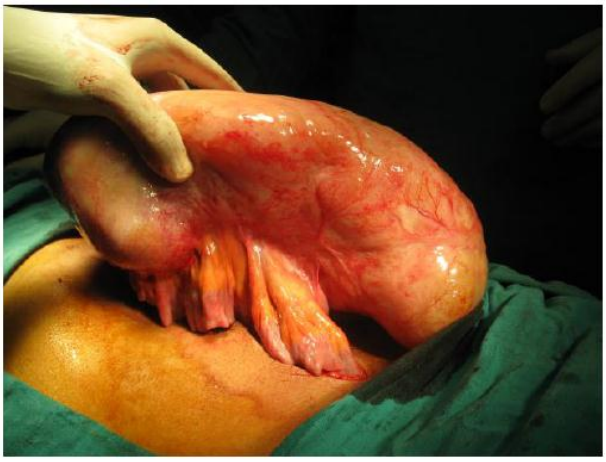

Figure 4: Operative part of this voluminous tumor carrying away part of the small intestine.

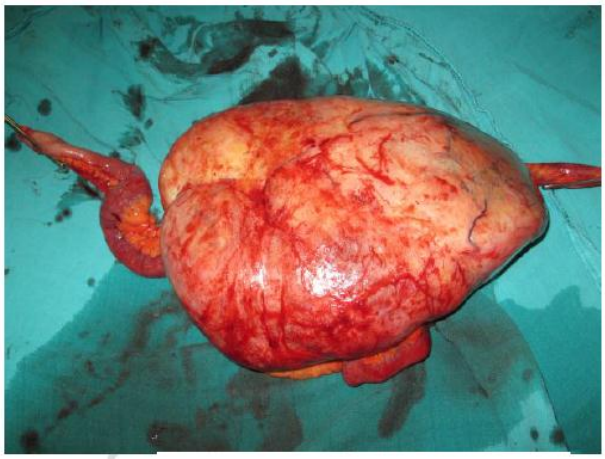

Figure 5: tumor invading mesentery and bowl.

Clinical examination showed a hard, fixed, painless mass, occupying the whole abdomen about 28 cm long, the rest of the somatic examination is unusual. The abdominal ultrasound: a voluminous pelvic abdomino mass, well limited, heterogeneous hypoechogene pre vertebral of 28cm of major axis (figure1).

The pelvic abdominal computed tomography (CT): a large heterogeneous tumor with necrosis zones, independent of the digestive tract, pushing the whole colonic frame together with the grisee loops measuring 32x30x7cm (figure 2). At colonoscopy, the different colon segments as well as the last ileal loop were normal. The biological assessment was without anomaly. The patient was operated by a median laparotomy to reveal an enormous mass occupying the entire abdominal frame at the expense of the mesentery, the rest of the exploration does not showed hepatic or peritoneal metastases no sign of peritoneal carcinosis.

We performed total tumor excision with segmental grele resection and termino-terminal anastomosis (Fig. 3, 4 and 5).

The postoperative follow-up was simple, the anatomopathological report showed a nodular mass weighing 5kg measuring 32x30x7cm, adjacent to the wall of the small intestine without obstructing the light developing on the mesenteric slope, the resected intestine measuring 30cm. On the histological examination, there was a low mitotic activity (less than 5/50) the appearance was in favor of a high-risk gastrointestinal stromal tumor. The immuno-histochemical study showed expression for CD117 and CD34.

The patient was treated with imatinib (Glivec) for six months with good tolerance. There was no evidence of recurrence on a five-year follow-up.

DISCUSSION

Digestive stromal tumors are rare mesenchymal tumors that can occur at any age, usually between 50 and 60 years, with a sex ratio close to 1.[1] Etiologic factors are unknown. They are most often localized in the stomach (60%), the small intestine (25%) and the colon in (5 to 10%).[2] They represent less than 1% of malignant tumors of the digestive tract. In the small intestine, excluding lymphomas, they account for 20% of malignant tumors.

Extra-digestive and especially mesenteric forms are more rare: less than 5% of all digestive stromal tumors.

Clinical symptomatology is variable and costs of seat and tumor size. Our tumor is remarkable for its mass of 5Kg and its size of 32 cm. The only case, the largest voluminous tumor, never described in the literature.

The clinical diagnosis is often delayed, which explains why most of these tumors are discovered at an advanced stage of abdominal mass. Digestive haemorrhage is the most frequently observed clinical sign.[3]

The discovery of an abdominal mass is found in 40% of cases[2] as was the case in our patient.

Stromal tumors most often determine on ultrasound a large tissue mass of polylobed contours, homogeneous or heterogeneous hypoechoic.[1,4]

The abdominal CT can show a voluminous tumor with preferential exoluminal development, polylobed contours, heterogeneous density with necrosis zones.[2,3] The computed tomography also makes it possible to make an assessment of local and regional extension. The main differential diagnosis is that of a malignant conjunctive tumor of the small bowel with lymphoma in its aneurysmal form.[1,4]

Treatment is essentially surgical, lymph node dissection is not routine because lymph node metastases are rare (less than 10%) and the risk of lymph node recurrence is limited (less than 5%). The prognostic factors are the large size of the lesion (greater than 8 cm), a strong mitotic index in histology and surgical resection margins invaded.[3,5] The justification for the use of imatinib (Glivec®) in digestive stromal tumors is related to its inhibitory action of the activated c-kit protein independently of its ligand. Imatinib is administered orally once daily. in the first instance in these situations.[2,5] For non-metastatic localized tumors, the treatment of choice is surgical resection as was the case with our patient.

In patients with a locally advanced tumor that is not immediately resectable, treatment with Glivec® should be instituted and a secondary surgical procedure should be discussed as soon as the maximum response is obtained. Recurrences are seen in 40% of cases despite a macroscopically complete excision with a median of onset of two years.[2,4]

CONCLUSION

The originality of our observation is represented by this enormous stromal tumor of the mesentery of 32 cm of major axis weighing 5 Kilogram revealed by an asymptomatic isolated abdominal mass.

No conflict of interest

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