



Research Article

**A CASE REPORT OF MULTIPLE PRIMARY SMALL BOWEL ADENOCARCINOMA
IN YOUNG MALE**

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ABSTRACT

A 34 year old man presented with melena and features of anaemia for 2 months duration. He didn't have abdominal pain or distension, vomiting or borborygmi. His physical examination was normal except for pallor. Abdominal examination didn't reveal any significant findings. On work up his hemoglobin was 5 g/dl, renal and liver function tests were normal. Platelet count and coagulation profile was normal. Ultrasound abdomen didn't reveal any significant abnormality. Patient was stabilized with blood transfusions. Oesophago-gastroduodenoscopy and colonoscopy was normal and presented as obscure gastrointestinal bleed. Since patient had persistent melena single balloon enteroscopy was done which revealed a nodular elevated lesion with active bleeding in proximal jejunum suspected as a vascular lesion. Since patient had active bleeding from the lesion, argon plasma coagulation of lesion done and biopsy of lesion was taken as liver had lesions suggestive of secondaries. Since the patient had persistent bleeding in spite of argon plasma coagulation of lesion and biopsy suggestive of poorly differentiated adenocarcinoma he was taken up for surgery which revealed four lesions starting from duodeno-jejunal flexure to terminal jejunum with adjacent mesenteric node involvement. Enterotomy of first and fourth lesion was done. Since the second and third lesions were adjacent, resections with intervening segment of bowel with adjacent mesenteric nodes done. During surgery liver showed nodular elevated lesion and biopsy was suggestive of secondaries. Post surgery patient is on chemotherapy now. This case is reported since multiple small bowel carcinomas in young are rarely reported in literature. Also obscure gastrointestinal bleed require extensive work up and possible small bowel source should not be neglected.

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INTRODUCTION

Primary adenocarcinoma of the small bowel (SBA) is a rare malignancy that challenges physicians in both diagnosis and treatment. Primary adenocarcinoma is the most common histologic subtype of carcinoma of the small bowel, constituting 40% of cases (1). Carcinoid tumors are the second most common type, accounting for 36% of cases. The most important known risk factor is previous Crohn disease(2).SBA is associated with familial adenomatous polyposis, celiac sprue, cystic fibrosis, and peptic ulcer disease(3).

The clinical presentation and diagnosis of SBA are usually delayed. An average delay of 6–8 months is common primarily because small bowel carcinomas are not amenable to endoscopic examination, especially when they are distal to the duodenum(4).

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In one of the largest series published to date from the SEER program, duodenal tumors were shown to be more common (48%) than tumours of the jejunum (23%) and ileum (16%) and 30% of patients present with metastatic disease(5).

Case report

A 34 year old man presented with melena for 2 months duration. He had easy fatigability and shortness of breath. His appetite was good. He didn't have abdominal pain or distension, vomiting or borborygmi. There was no weight loss or other co-morbidities. Family history was not significant. On examination he was pale and there was no significant lymphadenopathy or hyper pigmentation. He had tachycardia. Examination of abdomen revealed no organomegaly, mass palpable or visible peristalsis. Per rectal examination showed melena. His hemoglobin was 5 g/dL, renal and liver function tests were normal. Platelet count and coagulation profile was normal. Ultrasound abdomen didn't reveal any significant abnormality. Patient was stabilized with blood transfusions. Oesophago-gastroduodenoscopy and colonoscopy was normal. Since patient had persistent melena single balloon enteroscopy

was done which revealed a nodular elevated lesion with active bleeding in proximal jejunum. Initially suspected as a vascular lesion.

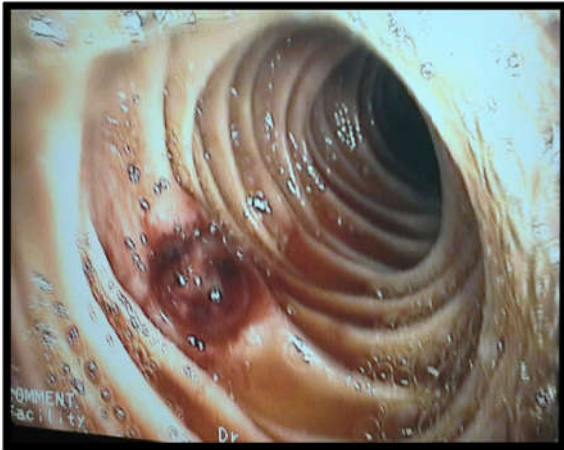


Figure 1 Single balloon enteroscopy showing nodular elevated lesion in proximal jejunum with bleeding

CECT abdomen showed multiple echogenic foci in both lobes of liver suggestive of vascular malformation or secondaries. Intestines appeared normal. Since patient had active bleeding from the lesion, argon plasma coagulation of lesion done and biopsy of lesion was taken as liver had lesions suggestive of secondary

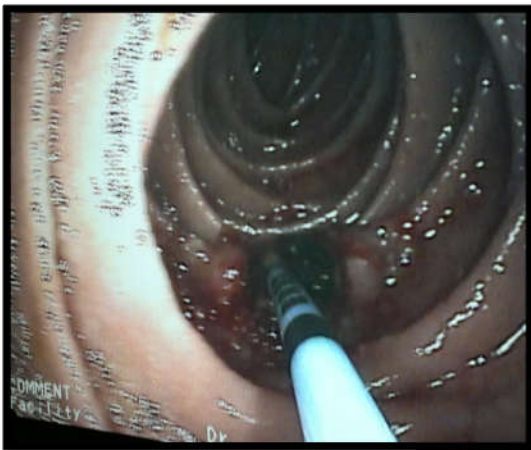


Figure 2 argon plasma coagulation of jejunal lesion

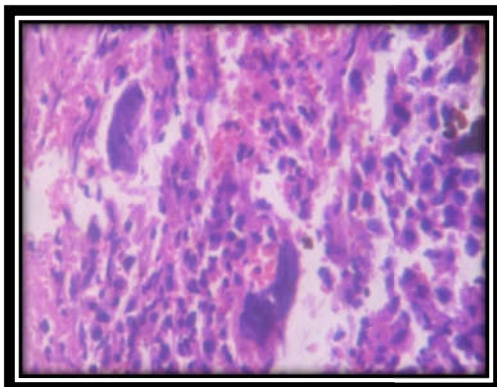


Figure 3 histopathological examination of lesion suggestive of poorly differentiated adenocarcinoma

Since the patient had persistent bleeding in spite of argon plasma coagulation of lesion and biopsy suggestive of poorly differentiated adenocarcinoma he was taken up for surgery which revealed four lesions starting from duodeno-jejunal

flexure to terminal jejunum with adjacent mesenteric node involvement.



Figure 4 Surgically resected lesions (enterotomy of 1st and 4th lesion & resection with intervening bowel as 2nd and 3rd lesion close to each other

Enterotomy of first and fourth lesion was done. Since the second and third lesions were adjacent, resections with intervening segment of bowel with adjacent mesenteric nodes done.

During surgery liver showed nodular elevated lesion and biopsy was suggestive of secondaries.

Histopathological examination of resected specimen was also suggestive of small bowel adenocarcinoma

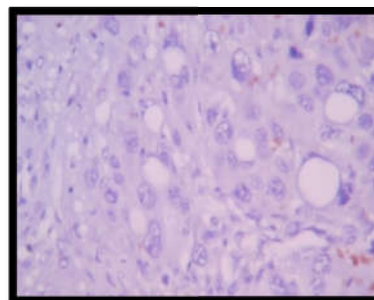
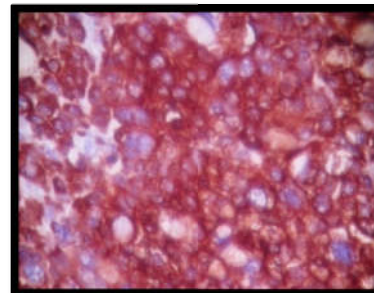
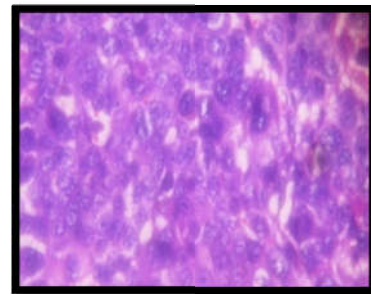


Figure 5 5A HPE poorly differentiated adenocarcinoma, 5B cytokeratin positive, 5C HMB 45 negative

Since lesion appeared melanotic immune histochemistry done which was cytokeratin positive, HMB 45 negative suggestive of adenocarcinoma.

DISCUSSION

Small bowel adenocarcinoma is rare and accounts for 1 to 2 % of all gastrointestinal malignancies and even rarer is multiple small bowel primary adenocarcinoma(6).

The peak incidence of small bowel adenocarcinoma is in the fifth and the sixth decade of life with a higher prevalence in the black population but this patient presented unusually in his third decade.

Identified risk factors for small bowel adenocarcinoma (SBA) include Crohn's disease, coeliac disease, and genetic syndromes such as familial adenomatous polyposis, hereditary nonpolyposis colon cancer (HNPCC), and Peutz-Jeghers syndrome(7) but this case presented as multiple small bowel adenocarcinoma without any risk factors.

Usual presentation is late due to distensibility of the small bowel wall and the liquid nature of its luminal contents. Clinical features depend upon the location of the lesion, duodenal lesions present as frank or occult GI blood loss, abdominal pain, biliary obstruction, rarely intestinal obstruction. Whereas jejunal and ileal lesions present as vague abdominal pain, nausea, vomiting and abdominal distension, coupled with overt or occult bleeding. Those with iron deficiency anemia present earlier.

This patient presented with obscure gastrointestinal bleed as both upper GI scopy and colonoscopy were normal inspite of his persistent melena. Cases with obscure GI bleed require extensive workup including capsule endoscopy or entereoscopy. Also both procedures are complementary to each other. In our case enteroscopy identified the lesion and it also provides an added advantage of performing interventions like argon plasma coagulation.

Also CT enteroclysis and CT enterography serve as alternative methods for diagnosis of small bowel cancers. By proving adequate luminal distension these methods delineate the tumours better.

Primary curative treatment is surgery and palliation is by 5-Fluro Uracil (5-FU) or combination regimens.

CONCLUSION

This case is reported since multiple small bowel carcinomas in young were never reported in literature. Also obscure gastrointestinal bleed require extensive work up and possible small bowel source should not be neglected.

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