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DUODENAL TUMOURS: UNUSUAL CAUSE OF IRON DEFICIENCY ANAEMIA

Muhammad Tariq Baqai

House No.3, Street No.46, F-8/1, Islamabad

INTRODUCTION

Primary tumours of small bowel are rare and often asymptomatic [1]. Symptoms are usually bleeding, obstruction or intussusception. Surgery is indicated as they have significant malignant potential.

CASE HISTORY

AA, 55 years old was admitted with complaints of backache of moderate intensity, abdominal pain and frequency of urine.

Abdominal pain was not related to intake of food or time of day. There was no history of nausea, vomiting or alteration of bowel habits. He denied any history of loss of weight, malena or frank rectal bleed.

On examination, the positive findings were pallor, koilonychia and soft palpable liver 2 cms below costal margin. On rectal examination, finger was stained with black coloured stool. Ultrasound of abdomen showed normal sized liver.

Blood examination showed Hb. 6.1 Gm/dl. MCV 65, MCH 20, reticulocyte count 1.8% ESR. 38 mm. Stool for occult blood was positive.

Upper GI endoscopy showed no lesion in esophagus, stomach or bulb. In the second part of duodenum, multiple sessile polyps projecting into the lumen with ulceration of the surface were seen. Biopsy showed that stroma of the polyp, contained large number of neutrophils as well as glands lined by columnar epithelium. The impression was of multiple, ulcerating tubulo-villous adenoma (fig.1 & 2). Surgery was advised but the patient refused.

Correspondence: Dr Muhammad Tariq Baqai, Associate Professor Medicine, House No.3, Street No.46, F-8/1, Islamabad

DISCUSSION

Small bowel, despite accounting for 90% of surface area of GIT, is an inhospitable terrain for development of neoplasm. Incidence of 1.4 per 100,000 as compared to 35.7 per 100,000 for colorectal carcinoma has been reported from U.S [1].

Primary tumours of small bowel may be benign or malignant. Adenoma account for the majority of benign small bowel tumours.

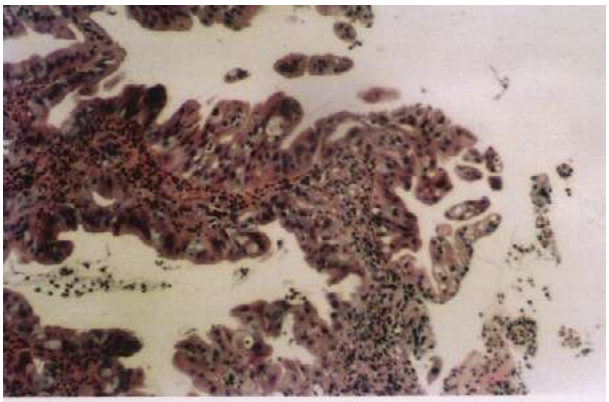

Fig.1: Tubulo villous adenoma with cenral stock H & E x 100

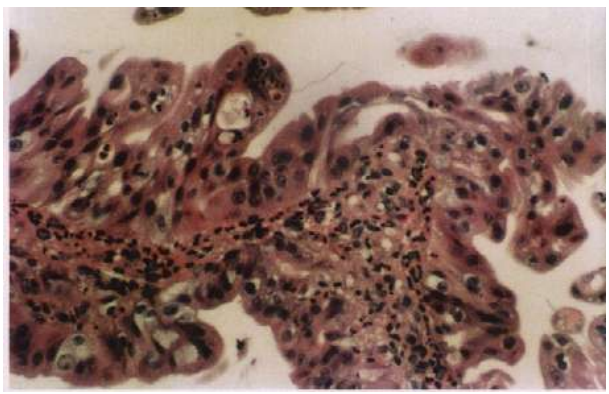

Fig.2: Tubulo villous adenoma. Mild nuclear atypyia is present H & E x 200

They were responsible for 65 % of all benign tumours in one series, first and second part of duodenum being the usual site [2]. Adenomas are divided into tubular, villous and tubulo-villous types. Tubular adenomas are small, spherical with stalk, villous adenomas are large & sessile. Some adenomas have tubular and villous element i.e. tubulo-villous adenomas. There is strong propensity for malignant change. Cancer has been reported in 35 to 60% of lesions and size is a poor predictor of malignancy [3].

More than half of all benign tumours remain asymptomatic and are found incidentlly at laparatomy or autopsy [2]. Symptoms, if present are abdominal pain, nausea and vomiting. One study found that small tumours greater than 40mm produced symptoms regardless of position or type [3].

Gastro duodenal bleeding is reported in 7-37% of people with small bowel tumours [2,3]. Large tumours may lead to partial or complete obstruction.

Our patient had non-specific abdominal symptoms for at least 10 months before presentation. He was anaemic.

Gastro-duodenoscopy is the investigation of choice for evaluation of small bowel lesions [2,3,4]. Our patient had lesion in the second part of the duodenum which should always be examined during gastro-duodenoscopy. Abdominal CT, contrast small bowel series and enteroclysis are useful radiological investigations [5]. CT enteroclysis, small bowel enteroscopy and video capsule are recent innovations.

CONCLUSION

Small bowel tumours are rare. They should be considered in a patient with un-explained anaemia or obscure GI bleeding.

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