



Small intestinal tophus mimicking tumor

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Received 16 April 2014; accepted 28 May 2014

Keywords:

Gout;
Intestinal tophus;
Monosodium urate
crystals

Abstract A 72 year old male with hypertension, diabetes mellitus type 2 and previous gouty arthritis presented with weight loss, nausea, and vomiting. Ultrasound and CT scanning of the abdomen revealed a circumscribed tumor mass of the jejunum, 3.7 cm in diameter. Microscopic examination of the resected jejunum revealed the tumor to be a gouty tophus. To the best of our knowledge, three cases of tophi in the large intestine have previously been reported but none in the small intestine.

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1. Introduction

Gout is a disorder of purine metabolism, reflected by elevated serum uric acid levels eventually leading to deposition of monosodium urate monohydrate (MSU) crystals, most commonly in the joints, kidneys, and soft tissues [1]. The typical course of disease involves progression through periods of asymptomatic hyperuricemia, followed by periods of acute attacks, an interval phase, and subsequent development of chronic arthropathy and tophi. Tophi are nodules of MSU deposits usually located within and around the finger or toe joints, over the olecranon process, in the helix of the ears, around the knees, and within the prepatellar bursae [1]. However, tophi have also been described in many atypical locations, like heart valves, vocal cords, breast, colon, eyes and spinal cord [1,2].

We report on a case of a 72-year old man with a tumor mimicking MSU tophus in the wall of jejunum, a localization which is hitherto undescribed.

2. Clinical history

2.1. Past history

The patient had had hypertension for the last 25 years initially treated with enalapril, thiazides, amlodipine, and bisoprolol, currently with metoprolol and amlodipine.

In 2001, high levels of serum uric acid at 0.61 mmol/l (normal 0.23–0.48 mmol/l) were first documented. Since then, the patient had 3 episodes of acute gouty arthritis in the big toe (2002–05) and was started on allopurinol treatment in 2002, currently receiving 300 mg daily. His uric acid levels have been normal since 2006 (last documented in 2010).

In 2003, the patient was diagnosed with diabetes mellitus type 2 and started on metformin to which was later added gliclazide. In the same year, he had a transient ischemic attack. Computed tomography (CT) of cerebrum showed multiple old but small infarcts. He was started on dipyridamol and low dose aspirin. In 2007, simvastatin was prescribed due to hyperlipidemia.

2.2. Present

In February 2013, the patient was admitted to hospital with gait ataxia, headache, nausea, and vomiting. There

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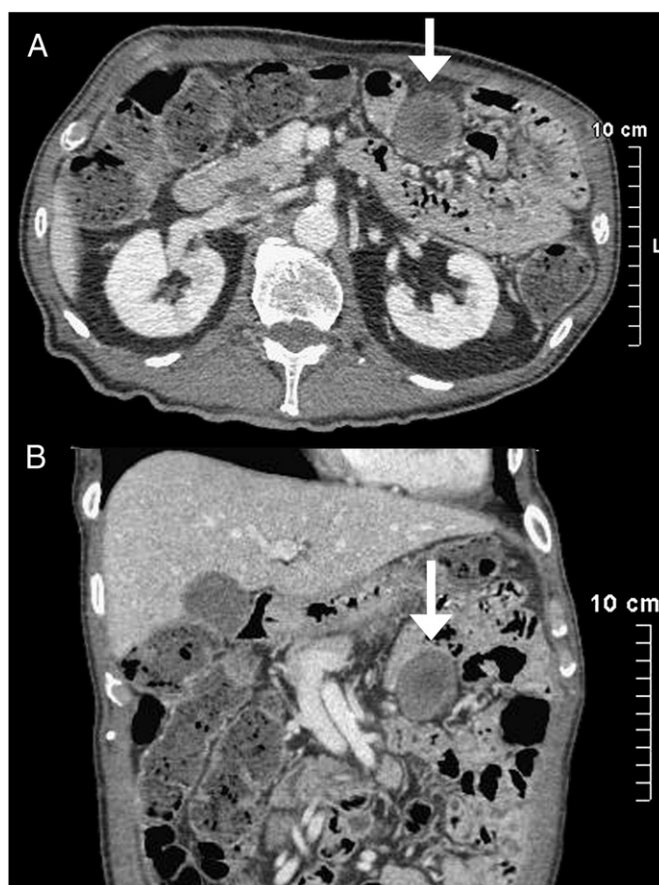


Fig. 1 CT scanning of abdomen (A, horizontal; B, sagittal) showing a well circumscribed tumor mass related to the mesentery of the small intestine (arrows) with central hypodensity.

was a 10 kg weight loss during two months prior to admission. Patient had been catheterized a few days before admission, due to urine retention.

A general physical examination revealed an enlarged prostate and a raised serum prostate specific antigen. CT scanning of cerebrum did not show any new infarcts.



Fig. 2 Macroscopic photo of the resection specimen. The cut surface of the subserosal tumor mass showing a sticky yellowish material.

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