



CASE REPORT

Multiple calcifying fibrous tumors in the small intestine and the mesentery

I-Tsou Tseng^{a,*}, Sung-Ting Chen^b, Zong-Zong Huang^c, Hong-I Tung^a,
Chen-Kuo Ker^{a,*}

^a Department of Surgery, Yuan's General Hospital, Kaohsiung City, Taiwan

^b Department of Pathology, Yuan's General Hospital, Kaohsiung City, Taiwan

^c Department of Surgery, Division of HBP Surgery, Kaohsiung Medical University Hospital, Kaohsiung City, Taiwan

Received 22 December 2010; received in revised form 16 March 2011; accepted 19 June 2011

Available online 11 February 2012

KEYWORDS

calcifying fibrous tumor;
calcifying fibrous pseudotumor;
inflammatory myofibroblastic tumor;
inflammatory pseudotumor;
peritoneal tumor;
mesentery tumor

Summary Calcifying fibrous tumor (CFT) is a rare and benign tumor. Histological features are hyalinized fibroblast-poor tissue, infiltrative inflammatory cells mainly composed of lymphocytes or plasma cells, and psammoma bodies or dystrophic calcification. The pathogenesis is unknown. We treated a 30-year-old man who suffered from abdominal pain, nausea and vomiting for 2 days. After X-ray examination, we did not find any ileus, hollow organ perforation or genitourinary tract abnormalities and therefore strongly suspected acute ruptured appendicitis. An appendectomy was therefore performed immediately. Multiple tumors were found during surgery, and pathological examination confirmed the diagnosis of CFT. After surgery, the previous symptoms were relieved and the patient recovered completely. However, another nodule in the greater omentum was found by a computed tomography abdominal scan 4 months later. For CFT with a large tumor and recurrent symptoms, we recommend complete excision as the best treatment. For a case of asymptomatic CFT with a small tumor, long-term follow-up should suffice.

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1. Introduction

Calcifying fibrous tumor (CFT) is an uncommon and benign tumor which was first described by Rosenthal and Abdul-Karim in 1988.¹ Most CFT cases have been reported in children and young adults.²

* Corresponding authors. Department of Surgery, Yuan's General Hospital, Number 162, Cheng-Kung 1 Rd, Kaohsiung City 80249, Taiwan.

E-mail address: titcsl@ms17.hinet.net (I.-T. Tseng).

CFT has been reported in various sites, such as soft tissues, the mesentery, the gallbladder, the peritoneum, and the pleura.^{1,3-6} However, multiple lesions are rare, and few cases have been reported, especially for mesenteric lesions.⁶⁻⁸ We searched PubMed using the key words "multiple calcifying tumor" and "mesentery," and found only 3 references. We add a new case of a male with multiple lesions in the mesentery, the small intestine and the mesenteric lymph node, and review the published papers on similar cases.

2. Case report

A 30-year-old male had an abdominal pain radiating to the right lower quadrant, accompanied by nausea and vomiting, for 2 days. The patient had had no other medical or systemic disease.

Physical examination, showed abdominal tenderness in the peri-umbilical area and the right lower quadrant with mild rigidity and distension. There was an abnormal WBC of $17,600/\text{mm}^3$. We then checked the patient's X-ray and highly suspected ruptured appendicitis; therefore, an appendectomy was performed immediately (Fig. 1). Since multiple nodules of a tan-white color were found in the small intestine, the mesentery and the mesenteric lymph node during the operation, we decided to perform local excision and a biopsy. The specimens were dissected and consisted of parts of the following: a mesenteric tumor (Specimen A), the small intestine (Specimen B), a mesenteric lymph node (Specimen C) and the appendix (Specimen D). They were all placed in formalin and sent to pathology for definitive diagnosis (Figs. 2A, and 2C, 2B). Specimen A had >10 miliary tumor masses sizing up to $0.8 \times 0.5 \times 0.4$ cm and was attached to the mesenteric surface. Specimen B contained multiple tumor masses measuring up to $1.0 \times 0.4 \times 0.4$ cm. The size of Specimen C was $1.0 \times 0.5 \times 0.4$ cm, and Specimen D was 4.1 cm in length

with no perforation. However, all the sections from Specimens A, B and C showed similar tumor masses which were well-demarcated and bore hypocellular tumors composed of fibroblast-like cells and sporadic inflammatory cells in a highly sclerotic background. Psammoma-like calcifications were easily seen (Fig. 3). There were atypical cells, necrosis or malignancy in any of these specimens. Immunohistochemically, the specimens were negative for CD34, CD117 and desmin but not for vimentin. Based on the above morphological and immunohistochemical results, a diagnosis of CFT was made. Panendoscopy was performed soon after the operation, but no specific finding was observed. Four months later, we followed up with a computed abdominal tomography scan, and a 7 mm nodule in the greater omentum was detected. The patient however denied any discomfort and, as a result, refused further medical investigation.

3. Discussion

CFT is a rare and benign tumor which has distinctive features, including hyalinized fibroblast-poor tissue, infiltrative inflammatory cells mainly composed of lymphocytes or plasma cells, and psammoma bodies or dystrophic calcification. In Table 1, the clinical features of CFT in the mesenteric region are summarized. To date, only five such cases have been reported including our present case. The gender ratio of females to males was 3:2, the ages of the patients ranged from 17 to 41 years, with a mean age of 26 years, and the tumor size varied from 0.8 to 9 cm. Clinical symptoms included abdominal pain, nausea, vomiting, tenderness, rebound pain and abdominal distension. There were two cases, excepting ours, that had experienced acute abdominal pain, nausea and vomiting and were presumed to present appendicitis. One was a 34-year-old male with symptoms in the omentum, and the other a 17-year-old female whose discomforts were in the peritoneal

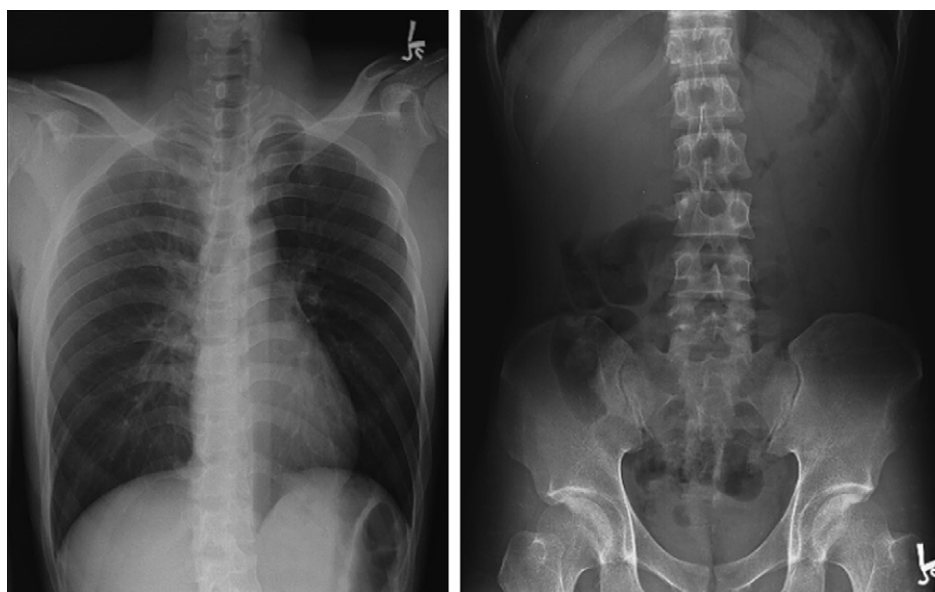


Figure 1 Essentially normal chest x-ray film and non special bowel gas accumulation on plain film.

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