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Mesenteric desmoid tumour presenting with recurrent abdominal abscess and duodenal fistula: A case report and review of literature



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ABSTRACT

INTRODUCTION: Desmoid tumors are locally destructive but histologically benign. Their management involves close observation and surgical, medical, or hormonal treatment.

PRESENTATION OF THE CASE: A 36-year-old male was admitted for abdominal pain and fever. A CT scan showed fluid collections and air within a mesenteric mass. Diagnostic laparotomy was performed with drainage of the abscess and biopsy of the mass. The pathology suggested a desmoid tumor. His fever and abdominal pain persisted. An endoscopy was performed, which demonstrated a fistula track in the third part of the duodenum. After a multidisciplinary discussion, consensus was to pursue surgical intervention. The patient underwent an en bloc resection of the tumor including a portion of the wall of the third part of the duodenum. The final pathology confirmed a desmoid tumor with a fistula track to the duodenum. The patient had a re-laparotomy on POD2 for intra-abdominal bleeding but was discharged without further events on POD7. He had no evidence of recurrence on follow-up at 11 months.

DISCUSSION: Desmoid tumors are rarely complicated by abscess formation or fistulization. The management of intra-abdominal desmoids in this setting is challenging, as patients are often symptomatic and unresponsive to medical management. Percutaneous drainage and antibiotics are often initiated as first-line treatment, followed by surgery or medical therapy after evaluation of resectability and tumor stage.

CONCLUSION: Rare complications can arise with intra-abdominal desmoid tumors. Principles of infection control should be applied in combination with optimization of oncologic outcome. A multidisciplinary approach helps to achieve both these objectives.

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1. Introduction

The work presented in this case study has been reported in line with the SCARE criteria [1].

Desmoid tumors, also known as aggressive fibromatosis, are locally destructive but histologically benign fibroblastic neoplasms that originate from any musculoaponeurotic or fascial structure in the body. They can occur sporadically or in association with familial adenomatous polyposis (FAP). Desmoids are categorized anatomically as intra-abdominal, abdominal wall, and extra-abdominal. Intra-abdominal desmoids typically occur in the intestinal mesentery and can cause complications such as obstruction, perforation, abscess formation, and hemorrhage [2–4]. This case describes a mesenteric desmoid that fistulized into the duodenum causing chronic abscess formation. It is rare for mesenteric fibromatosis to

present with fistula and few cases have been previously reported [5,6]. This case report discusses the optimal treatment of this situation and provides a literature review of the topic.

1.1. Patient information

A 36-year-old Caucasian male walked into a community hospital emergency room with acute upper abdominal pain continuing for three hours, along with nausea and low-grade fever. He denied a change in bowel habits, rectal bleeding, or weight loss. He was a healthy non-smoker, with no relevant medical or surgical history, no medications, and no family history of malignancy. On physical examination, the abdomen was soft and non-distended, with minimal left lower quadrant (LLQ) tenderness to palpation and no palpable mass. A CT scan showed a mesenteric mass with intra-abdominal abscess. He underwent a diagnostic laparotomy at the community hospital with intra-operative drainage of the abscess and biopsy of the mesenteric mass. The final pathology showed a desmoid tumor. His postoperative course was unremarkable, and

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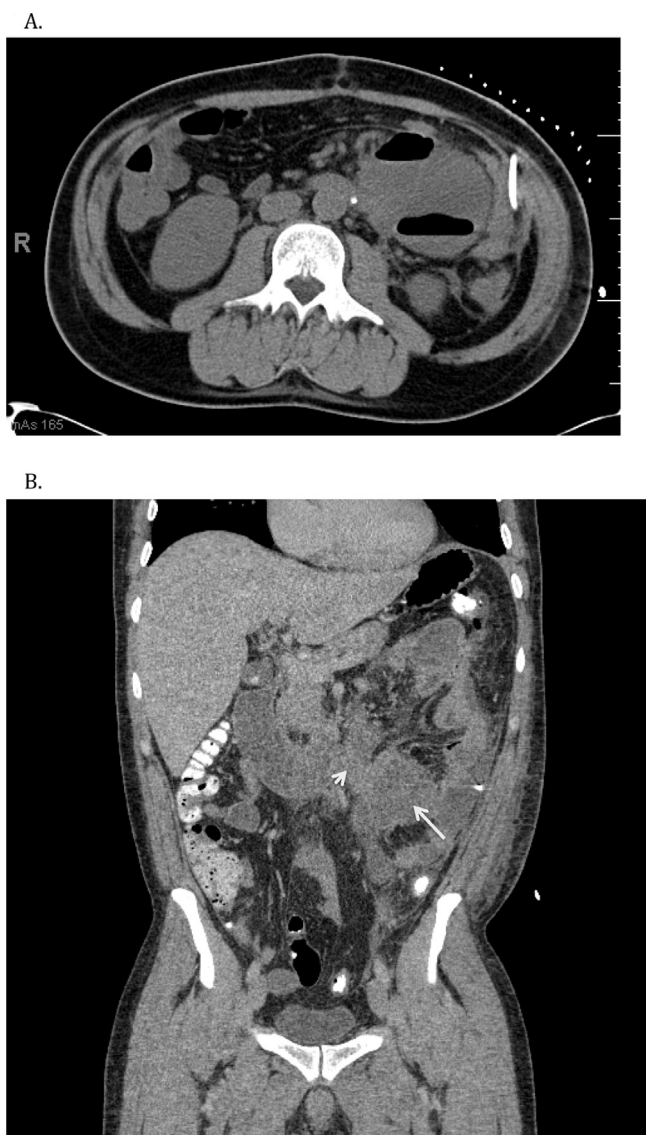


Fig. 1. A (axial view) B (coronal view), left lower quadrant mesenteric mass containing fluid collection and air locules, measuring 6.6 × 6.1 cm and about the cephalad and lateral component 6.6 × 6.9 cm. (long white arrow points to tumor, and short white arrow points to fistula track).

he was discharged home several days later to complete a course of oral antibiotics.

Three weeks later, he developed LLQ pain, fever, and decreased drainage from the left pericolic drain. He presented to the community hospital where the CT again showed an intra-abdominal abscess containing air within the mesentery mass (Fig 1). The drain was repositioned under ultrasound guidance. However, he developed a contrast-induced nephropathy from the CT and had a prolonged hospital stay for ongoing renal monitoring. The patient's family requested transfer to our tertiary hospital.

Following transfer, two additional abdominal drains were placed in an attempt to achieve infectious source control. He was maintained on broad-spectrum antibiotics but continue to have low-grade fevers. An upper and lower endoscopy was performed to assess for polyposis syndrome. During the upper endoscopy, a fistula track was found in the third portion of the duodenum, and a clip was placed just distal to this site. Both endoscopes were negative for polyps.

The patient's case was reviewed by a multidisciplinary sarcoma tumor board, and the outside pathology materials were reviewed.

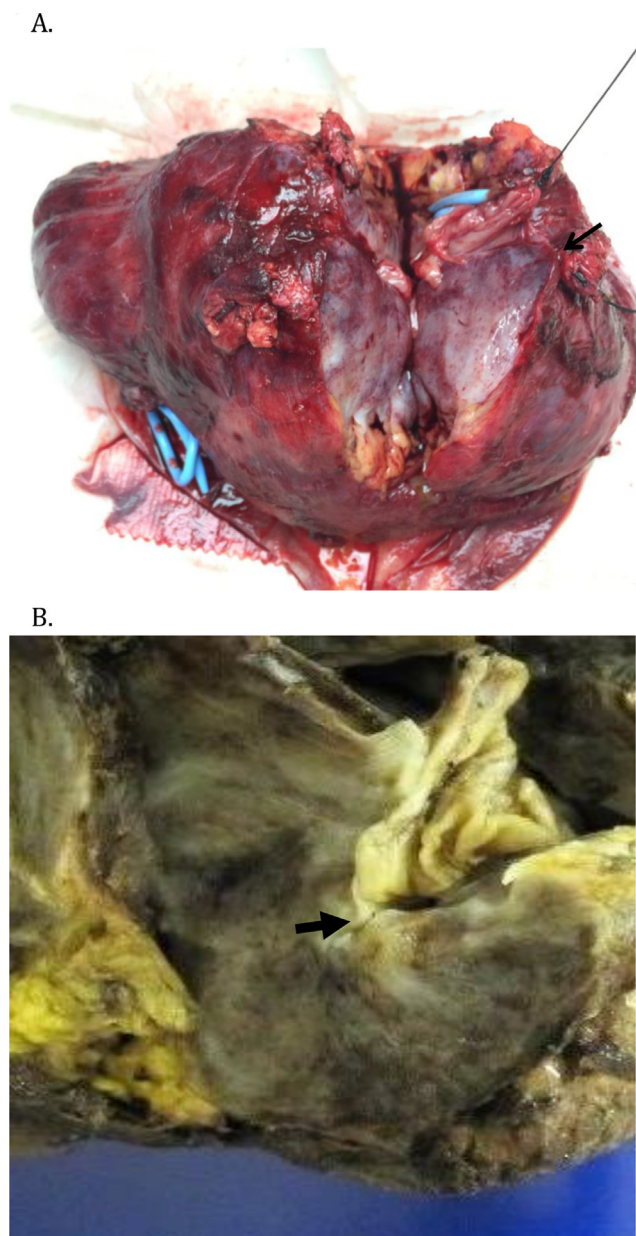


Fig. 2. A (gross specimen), B (Formalin fixed specimen). A portion of small intestine in relation to mesenteric fibromatosis with a fistula formation (black arrow points to the fistula track).

Failure of conservative management to improve the patient's condition and the finding of a neoplastic fistula led to the consensus to move forward with operative intervention. The patient underwent an en bloc resection of the tumor. A portion of the wall of the third part of the duodenum and a section of jejunum were removed with primary closure of the duodenum and side-to-side anastomosis of the jejunum. The tumor measured 12 cm and involved the small bowel mesentery and a portion of the jejunum, but the superior mesenteric artery and vein were uninvolved. There was no additional disease in the abdomen.

On postoperative day one, the patient's hemoglobin dropped from 10 to 7 g/L. He was tachycardic and required ongoing blood products and crystalloid to maintain his urine output. He was taken back to the operating room on postoperative day two for exploratory laparotomy. There was a large clot in the tumor bed. A small mesenteric vein was tied, and the staple line was oversewn to achieve hemostasis. His postoperative course was unremarkable

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