Original Research Paper

Volume-10 | Issue-1 | January - 2020 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

General Surgery

HISTOLOGICAL DILEMMA IN A STOMACH MASS – A CASE REPORT

Dr. S. Vijaya Babu M. S, Assistant Professor of General Surgery, Kurnool Medical College, Kurnool

Dr. M. Madhusudhana* Post Graduate Student of General Surgery, Kurnool Medical College, Kurnool
*Corresponding Author

Dr. G. Devi Prasad Post Graduate Student of General Surgery, Kurnool Medical College, Kurnool

KEYWORDS : GIST, Immunohistochemistry, Poorly differentiated Adenocarcinoma

INTRODUCTION:

Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal, or nonepithelial, neoplasms of the gastrointestinal (GI) tract. GISTs may be found anywhere in the GI tract, from the esophagus to the internal anal sphincter. The most common GI location is the stomach (56%), as reported in a 2015 review of multiple population-based studies, followed by the small intestine (32%), colon and rectum (6%), and esophagus (<1%).[1] Usually GIST (GASTRO INTESTINAL STROMAL TUMOR) may be confused with leiomyoma, leiomyoblastoma, schwannoma but in our case a preoperative endoscopy guided biopsy showed adenocarcinoma which was later proved to be GIST with post-operative histopathology and by immuno-histochemistry.

CASE HISTORY:

A 60 years old lady with upper abdomen for 4 months and early satiety for 2 months and the patient was well preserved and on investigation ultrasonography found to have a large lobulated heterogeneously hypoechoic lesion of size 20x19x15 Cms with internal anechoic cystic and haemorrhagic areas. On CECT abdomen also we suspected it to be GIST. Endoscopic biopsy showed poorly differentiated Adeno carcinoma of Stomach. On exploratory laparotomy morphologically tumor appears like GIST located in the body of the stomach which is adherent to the liver, spleen and diaphragm. During mobilization diaphragm was injured and it was repaired. We proceeded with partial gastrectomy with end to end anastomosis and R0 resection done. Specimen sent for histopathology and found to be malignant Gastro Intestinal Stromal Tumor which was later confirmed by immune histochemistry CD117 and DOG-1.

RESULTS:

Partial gastrectomy with R0 resection done in a case of suspected GIST by ultra sound abdomen and CECT. But Endoscopy guided FNAC showed poorly differentiated Adenocarcinoma which was post operatively confirmed to be GIST by Histopathology and immune histochemistry (DOG1, CD117 and c-kit).

DISCUSSION:

GISTs are often asymptomatic and discovered only as incidental findings on imaging studies or endoscopy performed for other indications. Patients with a symptomatic GIST often have symptoms that are related to the size and location of the tumor. This is likely due to their submucosal location, exophytic growth, and propensity to displace rather than invade adjacent organs. Patients presenting with large GISTs may have palpable tumors and present with pressure or pain or symptoms related to compression of adjacent organs. The increased awareness of GISTs has improved preoperative diagnosis. Suspected GISTs should be evaluated with contrast-enhanced computed tomography (CT) and/or magnetic resonance imaging (MRI). Typical findings are variable, depending on the size and aggressiveness of the lesion.[2] MALIGNANT POTENTIAL AND STAGING initially it was thought that the malignant potential of GISTs covered a broad spectrum from benign tumors to aggressive malignancies, with a high risk for distant metastases. As longer-term data have accumulated, it appears that most GISTs have some potential to metastasize and should not be considered truly benign. The major exception to this rule is very small (< 2 cm) gastric GISTS that also lack high-risk histologic features.[3] Gastric GISTs generally seem to behave less aggressively than tumors that arise in other locations. Current American Joint Committee on Cancer (AJCC) staging of GISTs includes tumor size, presence of nodal metastases, distant metastases, and grade (high grade is > 5 mitoses/50 high-power field).[4]

Fig : Laparatomy finding of stomach mass

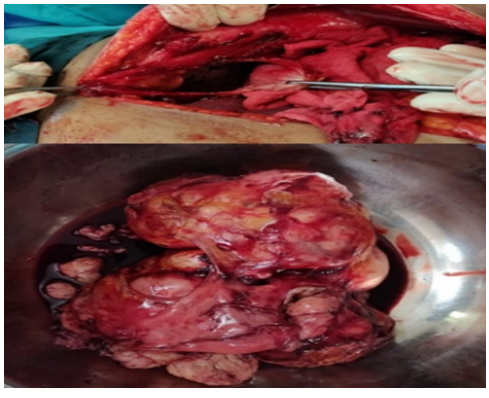

Fig : Resected neoplasma specimen

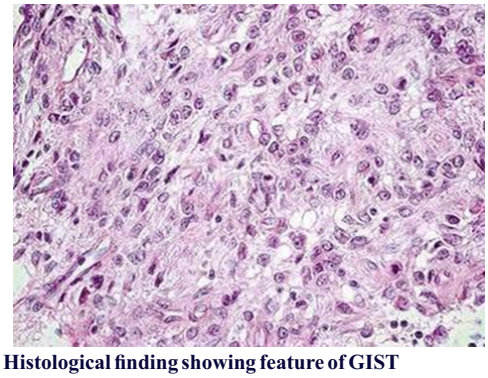

Fig : Histological finding showing feature of GIST

CONCLUSION:

A preoperative biopsy is not routinely necessary for a primary, resectable neoplasm suspicious for GIST. In fact, preoperative biopsy may rupture a suspected GIST and increase the risk of dissemination. However, if differential diagnosis includes entities such as lymphoma that would be treated differently, if neo adjuvant therapy is under consideration, or if there is metastatic disease, biopsy is appropriate.[5]

REFERENCES:

1. Søreide K, Sandvik OM, Søreide JA, Giljaca V, Jureckova A, Bulusu VR. Global epidemiology of gastrointestinal stromal tumours (GIST): a systematic review of population-based cohort studies. Cancer Epidemiol. 2015; 40:39-46.
2. Hong X, Choi H, Loyer EM, Benjamin RS, Trent JC, Charnsangavej C. Gastrointestinal stromal tumor: role of CT in diagnosis and in response evaluation and surveillance after treatment with imatinib. Radiographics. 2006;26(2):481-495.
3. Nishida T, Goto O, Raut CP, Yahagi N. Diagnostic and treatment strategy for small gastrointestinal stromal tumors. Cancer. 2016;122(20): 3110-3118. 13.
4. Van den Abbeele AD. The lessons of GIST–PET and PET/CT: a new paradigm for imaging. Oncologist. 2008;13(suppl 2):8-13.
5. Maingots Abdominal Operations 12 th edition 2013; 493-505.