CASE REPORT

PRIMARY CARCINOMA OF JEJUNUM – A CASE REPORT

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ABSTRACT: Primary Carcinoma of the Jejunum is very rare and very difficult to diagnose before surgery. No definite investigations are available to come into a pre-operative diagnosis though barium meal studies and capsule endoscopy may help in some cases to arrive at a proper diagnosis. It is characterized by hidden and non-specific symptomatology. Our patient presented with sub-acute intestinal obstruction with dyselectrolytemia due to persistent vomiting. The patient was subjected to a battery of tests and most of them were inconclusive. Ultimately an exploratory laparotomy with resection of diseased segment of jejunum and histopathological examination confirmed the diagnosis of primary carcinoma of jejunum.

KEY WORDS: Primary carcinoma of jejunum; Adenocarcinoma of jejunum; Small intestinal malignancy.

CASE REPORT: A 48 years female patient was admitted in this hospital in March, 2012 with complaints of acute upper abdominal pain with projectile vomiting and abdominal distension. She gave a history of intermittent acute pain in the upper abdomen with fullness of abdomen which started 3 months prior to admission. The pain and fullness were relieved after 2 to 3 bouts of vomiting and the patient refrained from taking solid food at night and preferred liquid diet. There was no history of fever, hematemesis, melena or past abdominal surgery. There was mild weight loss about 3 kg in last 3 months. Routine blood tests were normal except mild anaemia. Stool for occult blood test was negative. USG abdomen revealed mild hepatomegaly. UGI Endoscopy showed minute superficial ulcers in the duodenum. Colonoscopy revealed erythematous patches in caecum and ascending colon; biopsy from it came out to be chronic non-specific colitis. Small bowel enema was tried but failed. Barium meal X-ray revealed grossly dilated jejunal loops with abrupt cut off suggestive of intussusception. CECT abdomen could not be done due to residual barium in the intestines.

Exploratory laparotomy was done as medical management failed and no definite diagnosis could be made. A stricture was found about 150 cm from duodeno-jejunal flexure. Wide resection of the stricture with adequate normal margin followed by end to end anastomosis was done. The post operative period was uneventful and the patient was discharged after 12 days. The biopsy revealed well differentiated adenocarcinoma; no lymphovascular or perineural invasion; resection margins were free of tumour; TNM –stage-pT3NxMx. The patient was subjected to adjuvant oral chemotherapy. CECT abdomen and thorax were done after 1 month revealed no abnormality except mild thickening in distal jejunal wall with mild hepatomegaly. The patient was subjected to full course of adjuvant oral chemotherapy. Regular follow up were done and the patient is fine till date.

DISCUSSION: Primary carcinoma of small intestine is very rare and represents 1 – 5% of all gastrointestinal malignancies in Europe and USA (1, 2, 5, and 6). Adenocarcinoma accounts for 23 – 69% of all malignant small bowel tumours. The most common location is duodenum followed by

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jejunum (3, 6). Early diagnosis is exceedingly difficult. No definite aetiology factors are found after studying the reported cases. The age incidence is 40 – 79 years and male to female ratio is 1.4:1 (3). They are usually adenocarcinomas found mostly (80%) about 60 cm from Treitz's ligament (3, 7). They metastasize late to mesenteric and pre and para aortic lymph nodes. Metastasis to liver, lungs and bones generally occur in late stages. The polypoid stenosing variety is more common than annular type (8, 9). The clinical presentations are bizarre and depend on the degree of obstruction which may be sub-acute to acute. Melena is not uncommon and almost all patients present with mild to moderate anaemia which may be the presenting symptom. The mean interval from initial onset of symptoms to diagnosis is 5 months (13). The pre-operative diagnosis is usually made by barium contrast radiography but can be made in few cases. Apart from Barium meal and Capsule endoscopic studies (10, 11), Push-type jejunal endoscopy (12) using a long forward view duodeno fiberscope and double balloon small intestinal endoscopy (11) may aid in pre-operative diagnosis. As a rule, wide resection of the jejunal segment containing the tumour with adjacent lymph nodes are performed but radical resection involving Superior Mesenteric Artery may be carried out in spreading disease. No clear cut evidence of enhanced survival rate with radical surgery. Role of adjuvant chemotherapy with 5 – FU / Adriamycin / Cisplatin / Oral chemotherapy (15) is controversial and no definite regimen has been established till date. The prognosis is variable and may be poor due to delay in diagnosis. The 5 year survival rate varies from 59 – 81% (17) in early cases (14) but falls to less than 15% in late cases. Meticulous follow up at regular intervals is mandatory for further treatment in case of any recurrence.

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Figure 1: Peroperative findings of growth with stricture of the jejunum and proximal dilated loops of small intestine.

Figure 2: Resected specimen showing the growth with the stricture inside the lumen of the jejunum.

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