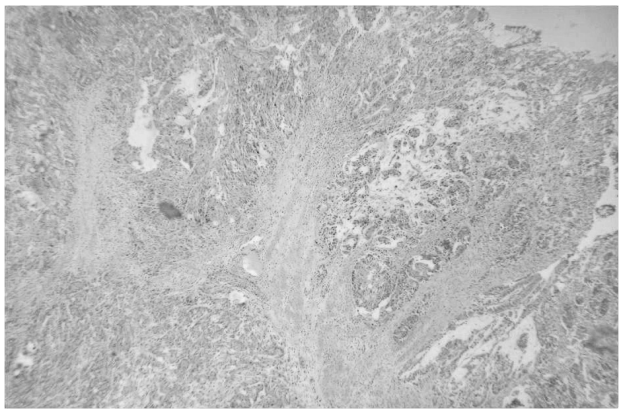
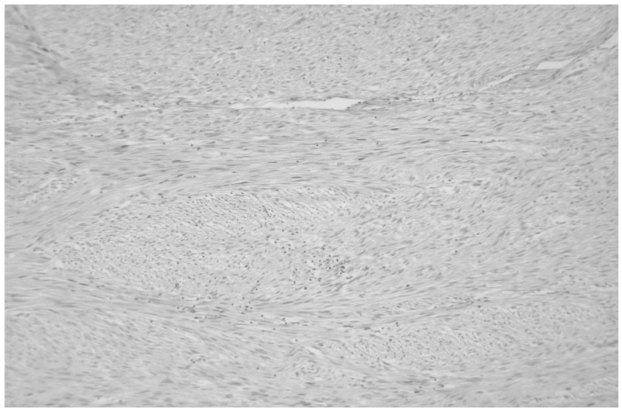
de 50% du volume tumoral, infiltrant la musculeuse (Figure 3). De nombreux emboles tumoraux ont été retrouvés. La clairance était de 13 mm et les limites longitudinales de la résection chirurgicale étaient saines. Un seul ganglion métastatique a été retrouvé sur 17 prélevés. La tumeur a alors été classée pT2N1.

Figure 3 : La tumeur rectale : adénocarcinome moyennement différencié (HEx40)



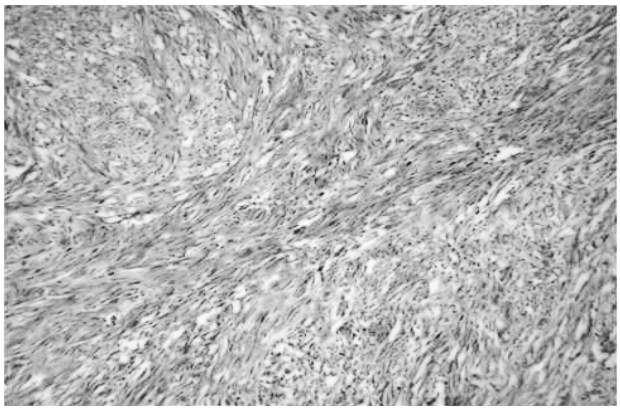
Le polype rectal répondait, quant à lui, à un adénome tubulo-villeux de haut grade. Une expression du c-kit par les cellules carcinomateuses a été recherchée et a été absente. La tumeur duodénale répondait à une prolifération mésenchymateuse de siège sous-muqueux, d'architecture fasciculée, faite de cellules fusiformes aux noyaux allongés, assez réguliers, rarement volumineux voire pléomorphes (Figure 4).

Figure 4 : La tumeur duodénale : prolifération mésenchymateuse faite de faisceaux entrelacés de cellules fusiformes régulières (HEx200).



L'index mitotique était nul. Des foyers peu étendus de nécrose étaient présents. La tumeur ulcérait la muqueuse duodénale. Elle arrivait au contact immédiat du parenchyme pancréatique, dont elle était séparée par une pseudo-capsule fibreuse, et restait à distance de la muqueuse gastrique. Six ganglions péri-gastriques ont été prélevés et étaient tous réactionnels. En immuno-histochimie, les cellules tumorales exprimaient intensément et diffusément le c-kit (Figure 5) et le CD34, et de façon plus faible et focale la PS100. Le diagnostic de GIST a été retenu. Devant son siège et sa taille, la tumeur a été considérée comme étant à haut risque de rechute ou de métastase selon la classification de Miettinen (2006). La patiente est décédée au 7ème jour des suites de complications opératoires.

Figure 5 : Les cellules de la tumeur duodénale expriment intensément et de façon diffuse le c-kit (x100).



Conclusion

Bien qu'elle soit de plus en plus rapportée dans la littérature, la survenue synchrone de GIST et d'ACR reste rare. L'étiopathogénie de ce phénomène est mal connue et bien que la plupart des auteurs pensent qu'il s'agirait plutôt d'un événement fortuit, des études génétiques et moléculaires complémentaires semblent être nécessaire avant de retenir une telle hypothèse.

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Service d'anatomie pathologique

** Service de chirurgie générale. Hôpital Habib Thameur. Montfleury. 1008- Tunis. Tunisie.*

Faculté de Médecine de Tunis - Université Tunis El Manar

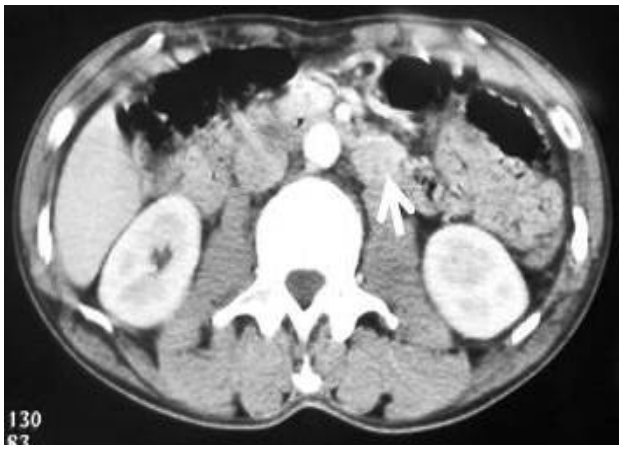
Massive gastrointestinal bleeding caused by small stromal tumour of the jejunum

Gastrointestinal stromal tumours (GISTs) are a group of rare tumors of the digestive tract that constitute about 1% of all gastrointestinal cancers (1). In about 60% of patients, these tumors are localized in the stomach, whereas in 20% it has been seen in the small intestines (2).

GISTs are usually small (Size < 2 cm), asymptomatic and can be found incidentally during irrelevant abdominal surgery such as gynecologic procedures, hepatobiliary surgery and other interventional techniques such as CT or routine endoscopic examination (1). When a symptomatic GIST is localized in the gastrointestinal tract, the most common symptoms are occasionally caused by the mechanical effect of the tumour (3). Massive lower gastrointestinal bleeding is a rare and unusual symptom of GISTs (4).
We report a rare situation of massive gastrointestinal bleeding caused by small stromal tumor of jejunum.

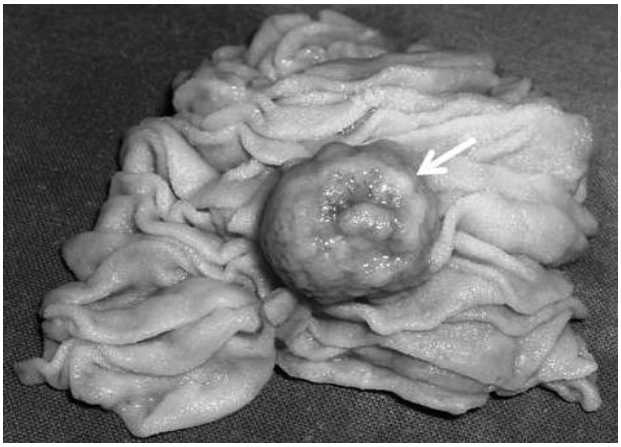
Case report
A 40-year-old man, was taken into emergency care for gastrointestinal bleeding of great abundance (Hg = 5 g / dl) externalized in the form of melena. After stabilization of hemodynamic status (Hg = 10 g / dl), Colonoscopic and gastroscopic evaluations were normal and could not reveal the origin of the bleeding. The abdominal CT scan had revealed a submucosa tumor of 1 cm at the first jejunal loop that took so intense the contrast (Figure 1).

Figure 1 : Abdominal CT scan shows a tumor of 1.5 cm at the first jejunal loop that took so intense the contrast (White arrow)



This tumor was confirmed by a jejunoscopy. During the preoperative period, the patient received 4 units of blood transfusions and was scheduled for emergency surgery. The incision was a midline laparotomy broad exploration had revealed the presence of intraluminal tumor at the first jejunal loop by 1 cm in diameter (Figure 2), the base sitting on the mesenteric border. We performed a mobilization of the duodeno-jejunal, a detachment of kocher, a uncrossing, a resection of the first jejunal loop with duodenojejunal side to side anastomosis, between the antimesenteric edge of the third duodenum and that of the second jejunal loop. The postoperative course was uneventful. Pathological examination of the specimen revealed a GIST originating from the jejunal wall that was composed of fusiform cells. It was 1.5 cm in size. We detected no ulcerations on the mucosal area. The mitosis index was 1 in 50 higher fields, and the Ki-67 value was under 1%. On immunohistochemical examination, CD117 and smooth muscle actin was diffusely positive, S100 was focal positive, and desmin and CD34 were negative. Proximal and distal surgical margins were clear. After falling 3 years, no recurrence was diagnosed.

Figure 2: A Specimen photo: We found a 1.5 cm tumor located at the first jejunal loop with sign of recent bleeding (White arrow).



Conclusion
Massive lower gastrointestinal bleeding is a rare and unusual symptom of stromal tumor of the jejunum. When Colonoscopic and gastroscopic evaluations are normal, we have to perform an angiographic selective embolization or an abdominal CT-scan to diagnose this tumor. An emergency surgery is indicated to treat complicated GISTs in the absence of a technical platform that allows a selective embolization.

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Amin Makni, Wael Rebai, Faouzi Chebbi, Sofiene Ayadi, Amin Daghfous, Zoubeir Ben Safta
Department of General Surgery 'A', La Rabta Hospital. Tunis. Tunisia
Tunis Medical School
Tunis El Manar University
