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TOTAL GASTRECTOMY IN A PATIENT WITH ABSCEDED GASTROINTESTINAL STRUM TUMOR

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Abstract: Gastrointestinal stromal tumor (GIST) is a mesenchymal tumor, predominantly affecting the stomach, in the gastrointestinal tract (GIT). It is rare, accounting for about 0.1-3% of GI tumors. These neoplasms can be asymptomatic, but in the case reported, they produced epigastric pain, weight loss and vomiting. Upper digestive endoscopy showed a vegetating lesion in a small proximal curvature, with purulent drainage. The lesion was biopsied, revealing a nonspecific chronic inflammatory process. Abdominal CT identified a contiguous tumor of the stomach, with formation of an air-fluid level, partially rejecting the left hepatic lobe. Diagnostic laparoscopy was indicated, converted to conventional laparotomy: bulky, solid-cystic lesion, measuring 15 cm, occupying the proximal 2/3 of the lesser gastric curvature. The lesion was biopsied, revealing a nonspecific chronic inflammatory process. Abdominal CT identified a tumor contiguous to the stomach, with formation of an air-fluid level, partially rejecting the left hepatic lobe. In the aforementioned report, the most striking was the presence of fetid eructations produced by tumor necrosis; possibly, with the growth of the lesion, with invasion of the stomach lumen, determining an intratumoral abscess, and generating the clinical picture described. vegetating lesion in small proximal curvature, with purulent drainage. Despite this, because the lesion was well circumscribed, without rupture, there was no tumor dissemination, not even a picture of abdominal sepsis. Total gastrectomy and Roux-en-Y esophagojejunostomy were performed, with histopathology of the mesenchymal neoplasm piece compatible with GIST, showing 4 mitoses/50 fields (40x). The patient had a satisfactory evolution, being discharged from the hospital on the tenth postoperative day.
Keywords: GIST; tumor; lesion.

INTRODUCTION

77-year-old woman, farmer, born in João Pessoa-PB. She reported epigastric pain, postprandial vomiting and intermittent fetid belching for 1 year, associated with a weight loss of 20 kg. Upper digestive endoscopy showed a vegetating lesion in a small proximal curvature, with purulent drainage. The lesion was biopsied, revealing a nonspecific chronic inflammatory process. Abdominal CT identified a tumor contiguous to the stomach, with formation of an air-fluid level, partially rejecting the left hepatic lobe. Diagnostic laparoscopy was indicated, converted to conventional laparotomy: bulky, solid-cystic lesion, measuring 15 cm, occupying the proximal 2/3 of the lesser gastric curvature. Total gastrectomy and Roux-en-Y esophagojejunostomy were performed. Histopathological specimen revealed mesenchymal neoplasm compatible with gastrointestinal stromal tumor (GIST), exhibiting 4 mitoses/50 fields (40x). The patient had a satisfactory evolution, being discharged from the hospital on the tenth postoperative day. In the follow-up of three and six weeks, there was good clinical recovery, with weight gain.

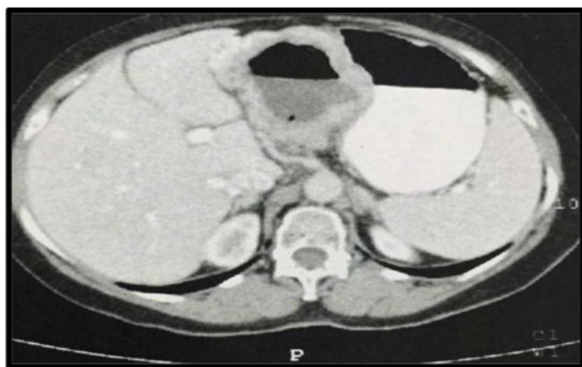

Figure 1: Computed tomography of the abdomen showing a tumor contiguous to the stomach with the presence of an air-fluid level partially rejecting the left hepatic lobe.

DISCUSSION

GIST is a mesenchymal tumor, predominantly affecting the stomach, in the gastrointestinal tract (GIT). It is rare, accounting for about 0.1-3% of GI tumors. These neoplasms can be asymptomatic, but in the case reported, they produced epigastric pain, weight loss and vomiting. More striking, however, were the fetid belching produced by the necrosis of the tumor; possibly, with the growth of the lesion, there was invasion of the stomach lumen, determining an intratumoral abscess, and generating the clinical picture described. Despite this, because the lesion was well circumscribed, without rupture, there was no tumor dissemination, not even a picture of abdominal sepsis.

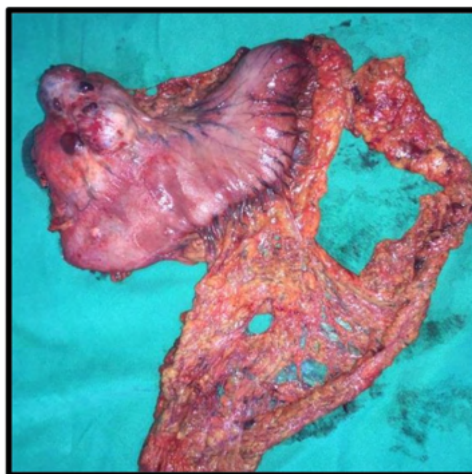

Figure 2: Surgical specimen showing a lesion in the lesser curvature of the stomach.

FINAL CONSIDERATIONS

We reported a case of intestinal intussusception preceded by cholangitis. The surgical finding represented the coexistence of three patterns of acute abdomen: inflammatory due to bile duct infection and obstructive/vascular with an invaginated jejunal segment, with ischemia, obstructing intestinal transit.

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