

BOWEL INJURY WITH AN UNEXPECTED TWIST. A CASE REPORT WITH REVIEW OF THE LITERATURE

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Introduction

Granular cell tumour (GCT) of caecum is a common tumour in a rare site with diagnostic challenge, but has malignant potential. GCT also known as Abrikossoff tumour is a benign neoplasm that is usually seen in the fourth to sixth decades of life. It is most frequently seen in the oral cavity, skin, and subcutaneous tissue. Gastrointestinal tract involvement is uncommon, in which esophagus is the most commonly affected site.

Conclusion

This case emphasizes the need to consider GCTs of the GI tract when **asymptomatic lesion can be found incidentally** in the colon of a trauma patient was the unexpected twist.

Case Report

45 years old Indian gentleman with no known premorbid conditions alleged motor vehicle accident. He was a motorbike rider and got hit by a car from the front. Post trauma, he complained of severe abdominal pain. During his primary survey, noted free fluid at Morrison's pouch. Other examinations were unremarkable. Hence, a CECT abdomen & pelvis revealed features suggestive of mesenteric and small bowel wall injuries likely at the right lower abdomen with moderate haemoperitoneum. Patient was immediately prepped to OT and proceeded with exploratory laparotomy.

Intraoperatively noted Morel-Lavallee at lower anterior abdominal wall with multiple transected bridging veins and haemoperitoneum upon entering. Otherwise there were a 3 segment buckle handle injuries at small bowel with active bleeding from mesenteric tear site: -5 cm from ileocecal junction: 20cm of devascularized bowel, 50cm from ileocecal junction: 20cm of unhealthy bowel and 100 cm from ileocecal junction : 10cm unhealthy bowel.

Caecum also appeared dusky, and unable to appreciate pulse over the ileocolic artery. Hence a right hemicolectomy was done along with 120cm of small bowel resection. Remnant small bowel about 140cm from duodenal jejunal junction was brought as a double barrel stoma. (ileostomy at the RHC and mucus fistula at the LHC). Stoma siting was done at the upper abdomen due to Morel-Lavallee at lower abdomen.

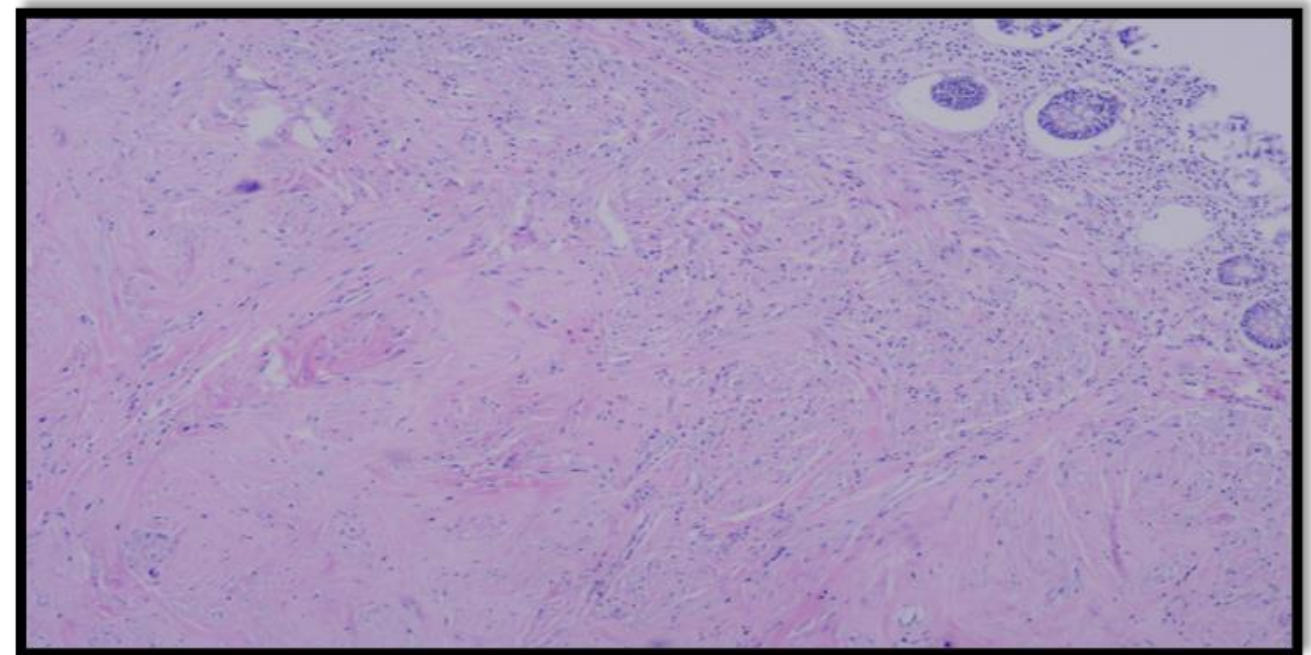


Figure 1

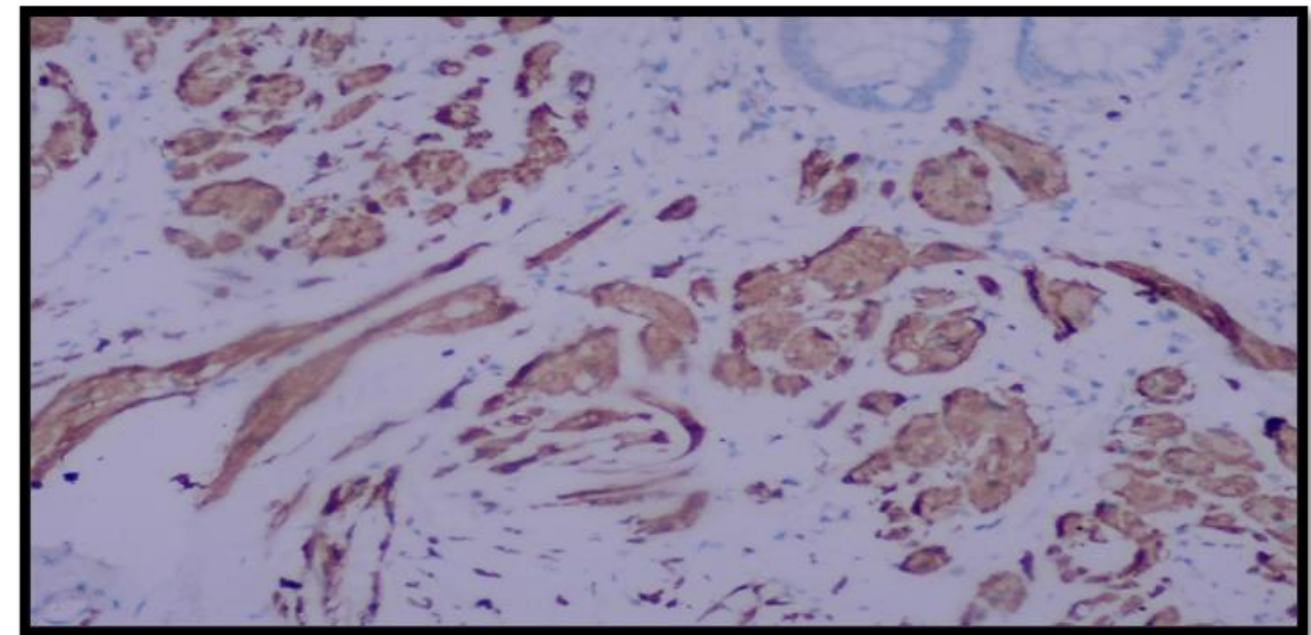


Figure 2 S100 : Positive

Specimens were sent for histopathological (HPE) examination. HPE revealed Right hemicolectomy specimen is consistent with small bowel ischaemia with changes of serositis. A submucosal nodular lesion (at the caecum) composed of a fairly circumscribed non encapsulated lesion which represents a granular cell tumour. Fairly circumscribed non capsulated submucosal lesion composed of granular cells tumour arranged in nest and sheets. These cells are rounded to polygonal with small rounded vesicular nuclei and abundant coarse granular cytoplasm (figure1). Colonoscopy of residual bowel was unremarkable. Subsequently he underwent a reversal of stoma 5 months later.

Discussion

GCT was described for the first time by Abrikossoff in 1926. The occurrence of GCT in the gastrointestinal tract is rare, accounting approximately for 8% of all tumours. In this article, we report a case of GCT involving caecum, which primarily occur in the right colon and typically a benign neural tumour of Schwann cell origin that occurs usually as a solitary painless nodule in the dermis or subcutis.¹ The details of which are reviewed with emphasis on incidentally diagnostic of this tumour in a trauma patient with bowel injury. Patients were generally asymptomatic. Colonic GCT is mostly found incidentally during colonoscopy or surgical resection as a solitary submucosal sessile nodule, although, some may cause rectal bleeding.¹ The most common symptoms were hematochezia and abdominal pain. Male/female ratio was 7:4; age range was 40-67 years.² The final diagnosis of GCT is based on histopathology findings. The typical pathological characteristics of GCT and **positive staining for S-100 protein** support an accurate diagnosis (figure 2).²

Acknowledgement

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Reference

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