An Unusual Cause of Upper Gastrointestinal Bleed

Paras Kathuria*, Neha Kapoor**, Premashis Kar***, Suresh Kumar†, Naresh Kumar‡

Malignant soft tissue tumours of anterior abdominal wall is not a common entity comprising < 1% of adult malignant growths.1 They arise from musculoaponeurotic fascia of anterior abdominal wall and are generally aggressive tumours with high incidence of local recurrence (25%) and propensity for distant metastases.2 They generally present as painless, rapidly growing abdominal wall mass which can cause complications when it involves the surrounding structures. Its presentation as gastrointestinal bleeding is extremely rare.

We present a case of 40 year old non-alcoholic male, a diagnosed case of abdominal wall spindle cell tumour who had been operated twice in the last three years with wide local excision and skin grafting without any post-operative chemoradiotherapy, presented this time with swelling at the site of previous tumour excision for last six months and melaena for last one week. He complained of generalised weakness and weight loss for few months. There was no history of haematemesis, chest pain, dyspnoea or jaundice. On examination the patient was of average built. He was afebrile and haemodynamically stable. There was a firm soft tissue swelling on abdomen (10×10 cm size) with well defined margin having superficial ulcerations. Investigations showed microcytic hypochromic anaemia with deranged iron studies (S. Ferritin - 47.37 ng/dl, TIBC-358.6 ng/dl). His liver and kidney function tests were within normal limits. CECT of abdomen and thorax was suggestive of a heterogeneous enhancing solid cystic mass lesion of anterior abdominal wall with abdominal and mediastinal extensions. UGI endoscopy was suggestive of mass lesion over anterior gastric wall (about 5 cm × 5 cm) with central ulceration. Endoscopic guided biopsy from the mass was suggestive of tumour composed of spindle cells with ovoid to irregular nuclei with nuclear polymorphism (mitotic figures 10/10 hpf). Tumour cells were negative for S-100, CD -34, SMA and CD-117. The tumour was diagnosed as recurrent malignant spindle cell tumour with intra-abdominal and mediastinal extension. A gastroscopy opinion was taken but the tumour was found to be inoperable in view of its mediastinal extension. Finally the patient was started on chemotherapy in form of MAID regimen (mesna, doxorubicin, ifosfamide, dacarbazine) and radiotherapy. Patient is currently doing well after receiving 4 cycles of monthly treatment with further plan of debulking surgery.

Discussion

Our patient had undergone wide local excision with tumour free margins twice but the tumour recurred both times. Our patient had a stage 3 tumour since initial presentation but did not receive any chemoradiotherapy, which might be the cause of recurrences. The unique point in our case was that patient presented with upper GI bleeding as the tumour extended till stomach, which is very rare. Involvement of stomach leading to GI bleeding has been reported in cases of intra-abdominal and retroperitoneal soft tissue sarcomas3,4 but no case has been reported showing an abdominal wall tumour involving stomach leading to GI bleeding. So this case represents a rare manifestation of an abdominal wall tumour which has not been reported till now.

References