CASE REPORT

Reticulum Cell Sarcoma of the Large Intestine

The Role of Fiberoptic Colonoscopy

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A case of multicentric reticulum cell sarcoma with a localized colonic lesion is discussed. The history of a previously resected adenocarcinoma of the sigmoid colon increased the diagnostic dilemma in this patient. Of the preoperative diagnostic techniques used, only fiberoptic colonoscopy and biopsy provided an accurate diagnosis. Colonoscopy also allowed direct assessment of colonic obstruction secondary to the lymphoma.

During the last several years, fiberoptic colonoscopy has proved to be valuable in the diagnosis and treatment of large bowel disease. Through direct visualization and biopsy, common abnormalities such as inflammatory disease, diverticular disease, adenocarcinoma, and polypoid lesions may be accurately diagnosed (1). The management of less common lesions such as benign cecal ulcer (2), ascending colon hemangioma (3), and nodular lymphoid hyperplasia (4) has also been facilitated by colonoscopy. The present report describes the preoperative colonoscopic diagnosis of a malignant lymphoma of the splenic flexure.

CASE REPORT

In January 1973, an 87-year-old Caucasian man was admitted for the fourth time to the Yale-New Haven Hospital with a chief complaint of watery diarrhea and left upper quadrant fullness.

The patient had been in good health all of his life until he sustained a mild cerebrovascular accident at age 70. In 1958, at age 72, he was admitted to Yale-New Haven Hospital with complaints of abdominal pain, hematochezia, and narrowed stools. Sigmoidoscopy and barium enema revealed an annular lesion in the midsigmoid colon. An anterior sigmoid resection was performed. Histological examination revealed adenocarcinoma extending through the serosa without involvement of regional lymph nodes (Dukes Class B). The patient did well in the postoperative period and was followed as an outpatient for the next 14 years.

In July 1972, the patient was admitted for evaluation of a right-sided preauricular mass. A sialogram revealed a mass in the right parotid gland and a subtotal parotidectomy was performed. The mass proved to be a reticulum cell sarcoma. Although at surgery the tumor involved branches of the facial nerve, the main portion of the nerve was left intact and, subsequently, irradiation therapy was given (4000 rads).

Four months postoperatively the patient suffered his second cerebrovascular accident which resulted in a mild left hemiplegia. While hospitalized, blood was noted in the stools. A barium enema showed a large polypoid mass in the splenic flexure which was interpreted as an adenocarcinoma (Figure 1). Following a short convalescence at home, the patient was readmitted for treatment of his colonic lesion. Abdominal palpation revealed a large, slightly tender mass in the left upper quadrant and a liver of normal size. Bowel sounds were moderately hyperactive. The rectal examination was unremarkable. Neurological examination demonstrated residual evidence of the recent right occipital lobe infarction. Laboratory data revealed normal bilirubin, serum proteins, transaminase, and alkaline phosphatase. The hematocrit was 37%, white blood count was 6600/cu mm, and platelet count was normal. The liver scan was interpreted as normal while isotopic scanning of the spleen showed an area of decreased uptake thought to represent a malignant process. Electrocardiographic examination showed a first degree A-V block and left axis deviation.

On January 30, 1973, fiberoptic colonoscopy was performed using the 110-cm instrument (Model 9000 P, Amer-
Fig 1. Barium enema showing large polypoid mass in the splenic flexure without radiographic evidence of colonic obstruction.

American Cystoscope Makers, Inc.). No premedication was given and analgesia during the examination was unnecessary. Because of the previous sigmoid resection, the instrument was passed rapidly to the splenic flexure where a large intraluminal mass was discovered (Figure 2). The lesion was partially covered by stool although the colon distal to it was well prepared by prior cleansing. The mass had a reddish, granular surface that bled easily when touched. The large, sessile tumor filled the lumen except for a small area which allowed the proximal passage of the colonoscope. In this area a large amount of stool was present which provided evidence of the obstructive nature of the mass. Cytological washing and biopsies of the lesion were taken. No abnormalities were found in the distal portion of the colon or rectum during withdrawal of the instrument. The patient remained comfortable throughout the examination. No electrocardiographic or blood pressure changes were noted during the procedure.

The colonoscopic biopsies were diagnostic of reticulum cell sarcoma (Figures 3A and B). Because of the high degree of obstruction noted on colonoscopy, the patient underwent laparotomy 2 days later at which time a resection of the splenic flexure and end-to-end anastomosis were performed. At surgery, the spleen was found to be small and the liver