Varied presentations of gastrointestinal stromal tumour

C. V. Kantharia · R. Irpatgire · R. Y. Prabhu · R. D. Bapat · A. N. Supe

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Abstract Gastrointestinal stromal tumours (GIST) are soft tissue tumours arising from the mesenchyma in the gastrointestinal tract. These are rare tumours. However, over the past few years with the better understanding of the pathogenesis of GIST and better imaging facilities, the diagnosis is made more frequently. The characteristic diagnostic feature of GIST is the expression of CD34 and receptor tyrosine kinase KIT, CD117 by these tumours. The use of tyrosine kinase inhibitor imatinib mesylate has led to improved outcome. The presentation of GIST however remains non-specific, and varies depending upon the size and the organ of origin. We present a series of four cases of GIST with varied presentation.

Keywords Mesenchymal tumours · GIST · KIT · Imatinib

Introduction

Over the past few years with the better understanding of the pathogenesis of GIST and better imaging facilities, the diagnosis is made more frequently. As a result, now a standard protocol is being followed for the management of GIST. The use of tyrosine kinase inhibitor imatinib mesylate has led to improved outcome. The presentation of GIST however remains non-specific, and varies depending upon the size and the organ of origin. We present a case series of varied presentations.

Case series

Case 1

A 55-year-old male presented with haemoperitoneum at a primary care centre. He was operated there on emergency basis, when they thought it to be haemangioma of left lobe of liver. Patient was closed after controlling of haemostasis, and referred to us for further management. CECT scan done at our centre revealed a mass arising from the greater curvature of the stomach (Fig. 1). Patient was re-explored when a cystic mass with solid component was found in relation to the greater curvature of stomach. A total gastrectomy was done. Histopathology and immunohistochemistry confirmed it as malignant GIST. On six month follow up patient was found to be doing well with no evidence of recurrence on CECT scan (Fig. 2).

Case 2

A 55-year-old male presented with progressive dysphagia. Endoscopy showed mass at the lower end of oesophagus (Fig. 3). Histopathology and immunohistochemistry of the endoscopic biopsy was suggestive of benign GIST. Patient successfully treated with transhiatal oesophagectomy. Its

References

C. V. Kantharia · R. Irpatgire · R. Y. Prabhu · R. D. Bapat · A. N. Supe
Department of Surgical Gastroenterology,
Seth GS Medical College & KEM Hospital,
Parel, Mumbai - 12, India

A N Supe (✉)
E mail: avisupe@gmail.com
four years since the surgery and on follow up, the patient is asymptomatic. Periodic endoscopy and CECT scan are normal (Fig. 4).

Case 3

A 50-year-old female presented with fullness of abdomen. On clinical examination, a large mass occupying the peritoneal cavity was found. CECT scan confirmed the finding with evidence of intra-tumoural bleed (Fig. 5). USG guided biopsy of the lump was inconclusive. Patient was explored, when a large mass with solid and cystic component arising from posterior wall of stomach was found. It was involving almost the whole of abdominal cavity. There was also presence of intra-tumoural bleed. As the mass was fixed to retro peritoneum and involving major blood vessels, resection was deferred. Biopsy was taken. It revealed a spindle cell tumour which on further immunohistochemistry investigation confirmed it to be malignant GIST. The patient was started on imatinib mesylate. In six months time the tumour has shrunk significantly and she is awaiting definitive surgery (Fig. 6).

Case 4

A 60-year-old female with neurofibromatosis - type I presented with chronic GI bleed and anaemia. Upper GI endoscopy revealed a small tumour arising from the lateral wall of second part of duodenum with bleeding ulcer on the surface. Endoscopic biopsy revealed it to be GIST (Fig. 7). Patient was taken up for surgery when a Wedge resection of tumour with duodeno-jejunostomy was done. Histopathology and immunohistochemistry confirmed it as GIST. It is