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Research Article

A CASE OF INTESTINAL OBSTRUCTION WITH A HISTOLOGICAL SURPRISE

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ABSTRACT
A 65 years old female patient presented with pain in abdomen since 15 years, vomiting since 8-9 years and abdominal distention since 7-8 years. On examination there was tenderness in the right iliac fossa and exaggerated bowel sounds present. The X-ray erect abdomen of the patient showed multiple air-fluid levels suggesting Sub-Acute Intestinal Obstruction. CECT showed enhancing intraluminal lesion, with narrowing of the bowel in the Right Iliac Fossa suggesting ileal obstruction due to ill-defined intensity enhancing intraluminal lesions. Explorative laparotomy was done with resection and anastomosis. The tissue was sent for Histopathological Examination. Histopathology showed unifocal G1 (low grade) carcinoid tumor.

Keywords: *Intestinal Obstruction, Unifocal Carcinoid Tumor*

INTRODUCTION
Carcinoid tumor is a common tumor of small bowel and can present as small bowel obstruction, bleeding and ischemia. The carcinoid tumor can be unifocal or multifocal.
In this case report we describe a case of small bowel obstruction with symptoms persisting since many years.

CASES
A 65 years old female presented with complains of pain in abdomen since 15 years, vomiting since 15 years and abdominal distention since 7-8 years. Pain was localized to right iliac fossa, colicky, intermittent, non-radiating associated with abdominal distention. Vomiting was non bilious, non-projectile containing semi-digested food particles.
Since the last two years all the symptoms have aggravated with increased frequency and patient is unable to take solid food and is presently on liquid diet. Patient came to the hospital with complains of severe pain abdomen, distention and vomiting since 7 days. Patient had undergone laparoscopic cholecystectomy 2 years back for the same complains and the symptoms persisted. On per-abdomen inspection, the abdomen was distended with umbilicus central, all hernia orifices were normal and visible peristalsis-step ladder pattern seen. On palpation, tenderness was present in the right iliac fossa. On auscultation, exaggerated bowel sounds were present. All routine blood investigations were normal.
The R.F.T, L.F.T, Serum electrolytes all were within normal limits. X- ray erect abdomen showed multiple air-fluid levels with significant volvulae connivantes, giving the impression of Acute inflammatory bowel, acute to sub-acute high bowel obstruction.
The CECT Abdomen and Pelvis showed an ill-defined intensely enhancing intra-luminal lesion with luminal narrowing involving the lumen in the right iliac fossa at the level of common iliac artery bifurcation (L5/S1) level with proximal dilated and thick walled edematous ileal loop suggestive of stricture with ileal obstruction.
The patient underwent explorative laparotomy and a single stricture was found at about 20 cm from ileo-caecal junction in the ileum. Resection of the stricture and end to end anastomosis of ileum was done. The specimen was sent for histopathology and it was reported as Low Grade Carcinoid tumor (G1). The pathological staging was pT4NxMx.
After the histopathology report, the 24 hour urine 5HIAA was sent and it was within normal limits. The patient's recovery was uneventful and was discharged after 10 days.

DISCUSSION

The first description of carcinoid tumor was made by Lubarsch in 1888.Gastrointestinal tract [GIT] neuroendocrine tumor was first described by Oberndorfer in 1907 (Shekhar *et al.,* 2014). The prevalence of carcinoid tumors is 1-2 cases per 100,000 persons, slightly more common in African Americans (Jennifer *et al.,* 2014). The tumor arises from enterochromaffin cells primarily in the submucosa of the intestine. It can occur in any organ derived from the primitive endoderm but 64% originates in the GIT, with the commonest primary sites being the appendix, small intestines and rectum. In the small intestine, majority of the cases are found in the ileum, less commonly in the jejunum and rarely involving the duodenum (Jennifer *et al.,* 2014). Clinical presentation can be with non-hormonal symptoms secondary to tumor bulk and local reaction, or with symptoms of a functioning tumor, described as 'carcinoid syndrome'. The non-hormonal symptoms can present as intermittent abdominal pain, distension and can present as partial small bowel obstruction. These obstructive features may be due to peri-tumoral fibrosis or invasion, causing direct luminal strictures, or secondary to desmoplastic reaction leading to ischemic changes. The hormonal symptoms are due to carcinoid syndrome and occur secondary to the secretion of serotonin, tachykinins, bradykinins and prostaglandins. The main clinical features of carcinoid syndrome are 1 Diarrhea (83%) 2 Vasomotor changes (49%): Cutaneous flushing, erythema, cyanosis 3 Dyspnea (20%) 4 Bronchospasm (6%) 5 Pain 6 Pellagra 7 Carcinoid heart disease: Endocardial fibrosis often causing right sided heart failure (Ha and Tan, 2012; Henrietta, 2009). In patients presenting with symptoms of carcinoid syndrome urinalysis can be carried out for elevated 5-HIAA levels. Chromogranin A can also be used as a sensitive marker to identify mid gut carcinoid tumors, however, specificity may be low (Datta *et al.,* 2011). CT imaging with both arterial- and portal-phase imaging is helpful in differentiating the tumor from surrounding tissues and CT enterography may also be helpful for the elusive small bowel mass. Other diagnostic modalities include single photon emission computed tomography (SPECT) and positron emission tomography (PET). Scintigraphy with radiolabelled octreotide has also been successfully used to localize previously undetected primary or metastatic lesions, with a sensitivity of 80-90% (Moosavy *et al.,* 2011; Kitchens *et al.,* 2011). The principal management approach in these cases is surgical resection of the primary lesion and is the only curative option. With smaller lesions (<1cm) local resection is usually adequate. However, with lesions over 1.5 cm there is a high risk of recurrence and thus segmental resection is required with extensive clearance of the associated mesenteric lymph nodes (Moosavy *et al.,* 2011). Medical treatment involves use of somatostatin analogues like octreotide. Methysergide is no longer used because of retro-peritoneal fibrosis. Survival is nearly 100% for local tumors, 65 % for regional disease, 35% for distant metastasis (5 year survival).

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