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Case Report

Multiple carcinoid tumour of duodenum: an uncommon case

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ABSTRACT

A 45 years old female patient with complaints of pain in epigastric region since 1 year not responding to proton pump inhibitors underwent oesophagogastroduodenoscopy which showed two duodenal masses. On further investigations diagnosis was duodenal carcinoid tumour. Patient underwent Pylorus Preserving Whipples surgery.

Keywords: Carcinoid tumour of duodenum, Multiple carcinoid tumour of duodenum, Neuroendocrine tumour of duodenum, Pylorus preserving Whipples surgery

INTRODUCTION

Gastrointestinal tract is most common site for carcinoid tumors.[1] Carcinoid tumour of small bowel arises from enterochromaffin cells (Kulchitsy cell) found in crypts of Liberkuhn. Duodenal carcinoid tumour have incidence of < 4 % of all gastrointestinal carcinoid tumour.

CASE REPORT

A 45 years old female presented with complaints of pain in epigastric region since 1 year. There was no history of nausea, vomiting, loss of weight or appetite, altered bowel habits. She did not respond to proton pump inhibitiors.

Oesophagogastroduodenoscopy has done which showed two sessile masses in first and second part of duodenum. Biopsy was taken which was suggestive of neuroendocrine tumour. On immunohistochemistry both synaptophysin and chromogranin A was positive in tumour cells.

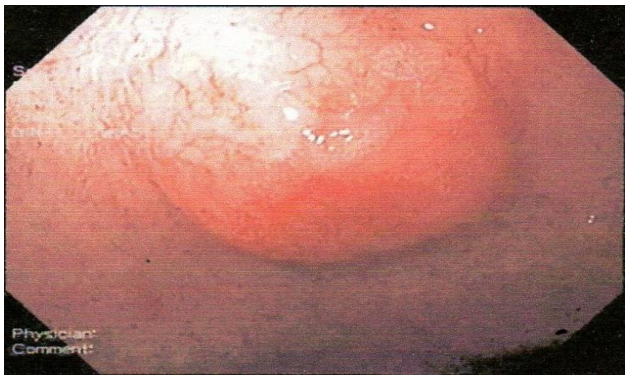

Figure 1: Endoscopic view of duodenal carcinoid tumour.

DISCUSSION

Carcinoid tumours are treated because of symptoms including carcinoid symptoms and potential malignant potential.[2]

Carcinoid syndrome characterized by episodic attacks of cutaneous flushing, bronchospasm, diarrhoea and vasomotor collapse was absent in this case. Around 75% of gastrointestinal carcinoids are smaller than 1 cm in diameter and approximately 2% of these associated with metastasis.

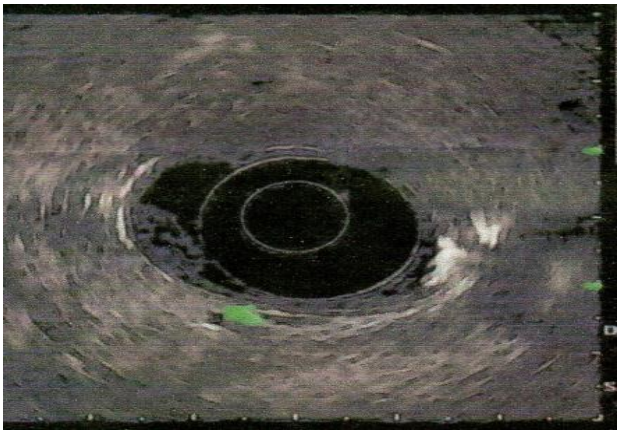

Figure:2 Endoscopic ultrasound showing duodenal carcinoid.

In present case OGD scopy showed two lesions in first and second part of duodenum. Endoscopic ultrasound showed lesions arising from mucosa which was separate from muscularis. Biopsy was suggestive of neuroendocrine tumour which was confirmed by immunohistochemistry (both synaptophysin and chromogranin A positive).[3] SRS (Somatostatin receptor scintigraphy) done to localize and stage the tumour. Computed Tomography of abdomen and pelvis and colonoscopy done which ruled out synchronous large bowel adenocarcinoma. Tumour size, site and presence or absences of metastasis are main determinant of treatment of patients with small bowel carcinoid tumour.[4] For tumor less than one centimeter in diameter without metastasis, a segmental intestinal resection is adequate. In this case as one tumour was near ampulla of vater, segmental resection was not possible.[1-4] Pylorus Preserving Whipples surgery was done. Patient is on regular follow up and asympyomatic for 2 years since surgery.[5]

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