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Original Research Paper

General Surgery

DIAGNOSTIC DILEMMA IN DUODENOJEJUNAL FLEXURE ADENOCARCINOMA

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ABSTRACT Adenocarcinoma of duodenojejunal flexure is extremely rare and sometimes difficult to diagnose.In this paper we report a case of a 45 years old lady presented with recurrent episodes of bilious vomiting,loss of appetite and loss of weight for 2 months. Surgical resection of these DJ flexure adenocarcinoma is also challenging because of the short mesentry and close proximity to the retroperitoneum and superior mesenteric artery.

KEYWORDS :

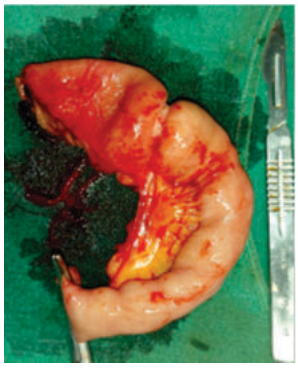
INTRODUCTION:

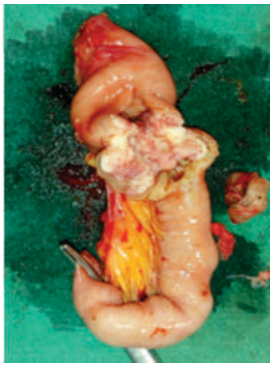
Primary small bowel neoplasm at the ligament of Treitz or duodenojejunal flexure are extremely rare and are encountered as an intraoperative surprise. The insidious onset and vague abdominal symptoms,coupled with difficulty in viewing this location on gastroduodenoscopy, makes diagnosis of neoplasms at ligament of Treitz particularly difficult[1].

Case Report:

A 45 years old lady presented with recurrent episodes of bilious vomiting,loss of appetite and loss of weight for 2 months.On examination severe pallor was present,with soft moderately distended non tender abdomen,with visible gastric peristalsis suggestive of gastric outlet obstruction. CECT of the abdomen was suggestive of superior mesenteric artery syndrome.Upper GI endoscopy revealed dilated stomach and proximal duodenum with no evidence of any mass lesion.

Exploratory laparotomy was performed in view of SMA syndrome with gastric outlet obstruction.However,a stricture with intraluminal mass was found at DJ flexure for which resection with duodenojejunal anastomosis was done.





Histopathological examination revealed well differentiated adenocarcinoma of duodenojejunal flexure upto muscle layer.

DISCUSSION AND CONCLUSION:

Small bowel malignancies are uncommon,comprising only 1-2% of gastro intestinal malignancies and 0.3% of all malignancies.Segmental excision of the fourth part of duodenum is challenging as it is a partially retroperitoneal structure[2]. GI endoscopy can be useful in evaluating regions up to the second part of the duodenum. It is pertinent to be aware of malignancies beyond duodenojejunal (DJ) flexure and investigate these patients with CT and enteroscopy.[4]

Surgical resection of these DJ flexure adenocarcinoma is also challenging because of the short mesentry and close proximity to the retroperitoneum and superior mesenteric artery[5].We were able to achieve wide surgical margins and establish continuity of the upper gastrointestinal tract. Our patient remains asymptomatic since then.

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