In October 2002, we received a call of a male patient, aged 43 years, from Medical C Unit of our hospital. His presenting complaints were generalized weakness and passage of black tarry stools per rectum. On clinical examination he was found to have severe anemia and a very vague mass in the hypogastric area. There was no history of pain abdomen and no previous history of peptic ulcer disease or jaundice. The investigations already performed showed hemoglobin of 5gm%, normal coagulation profile, normal upper and lower gastrointestinal endoscopy findings and normal barium studies. The ultrasound showed a mass in the hypogastric region, 10x8 cm in size, adherent to the urinary bladder and pelvic wall. The origin was not certain.

After he was shifted to our unit, a contrast enhanced CT of the abdomen was done showing a mass of 10x8 cm in the pelvic region attached to and pressing on the urinary bladder and adherent to the pelvic wall. Possibility of carcinoma and hemangiomatous lesion was considered. MRI was requested to find out the origin and operability of the tumor, showing the tumor to be arising from the pelvic wall, possibly a hemangioma.

These investigations took about 7 days. During this period at 2 occasions the patient suddenly collapsed. He had severe tachycardia, pallor and sweating. Systolic blood pressure dropped to 50-60mmHg systolic followed by severe haematochezia. He was resuscitated with blood transfusions and plasma expanders. He required 9 pints of blood to bring his Hb to 9gm%.

The help of the cardiology and cardiovascular units in Lady Reading Hospital Peshawar was sought for catheter embolization of the tumor. They had no previous experience of catheter embolization so they regretted.

Finally it was decided to go ahead with a laparotomy. Peroperatively, it was found that the tumor on CT and MRI was a highly vascular, pedunculated fleshy mass, with a jelly like surface, 10x8 cm in size arising from distal jejunum. It was attached to the antimesenteric border of the jejunum, with big vessels from the jejunal mesentery supplying the tumor. It was loosely adherent to the urinary bladder, pelvic wall and rectum. There were no enlarged lymph nodes or metastasis in the liver.

The tumor along with about 20cm of jejunum and a wedge of mesentery was excised and end to end anastomosis was performed. Patient recovered uneventfully. At six months interval follow-up, he was in good health with no local or distant recurrence.

The specimen histopathology report was — A stromal (mesenchymal) tumor of the jejunum, looking benign, but follow-up was advised.

**DISCUSSION**

Gastrointestinal Stromal tumors are the primary non-epithelial neoplasms of the gastrointestinal tract. The tumors are derived from the pleuripotential mesenchymal cells (interstitial cells or stromal cells) of the gastrointestinal tract. They

**ABSTRACT**

Gastrointestinal stromal tumors are relatively rare neoplasms. They are the primary non-epithelial neoplasms of the gastrointestinal tract derived from pleuripotential mesenchymal cells. They are capable of either partial or terminal differentiation along a variety of cell lines. They are the most common form of sarcoma of the gastrointestinal tract.

This is a case report of a 43 year old male who presented with severe anemia and history of bleeding per rectum, on examination having a mass in the hypogastric region. Post operative biopsy reported the mass as a mesenchymal tumor of the jejunum.

**Key words:** Stromal Tumors, Pleuripotential Cells, Sarcoma, Haematochezia.
are capable of differentiating along a variety of cell lines. Previously they were named Leiomyoma and Leiomyosarcoma but now the term Stromal Tumors is used because the biological behaviour of these tumors is unpredictable.

They are life threatening soft tissue tumors located generally in the upper gastrointestinal tract, approximately 60% in the stomach; 30% in small intestine and 10% in other parts of GIT. According to some, they are the most common malignant form of sarcoma (tumors arising from cells of mesoderm, muscle and connective tissue of gastrointestinal tract), but are still relatively rare.

There are about 12,000 new cases reported each year world wide. The incidence is highest in people aged 30-60 years; male to female ratio is 2:1.

The behaviour of the tumor can be predicted to some extent according to Amin's Classification:

<table>
<thead>
<tr>
<th>Size</th>
<th>No. of Mitosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign</td>
<td>&lt;5cm &lt;5/50HPF</td>
</tr>
<tr>
<td>Borderline</td>
<td>&gt;5cm &lt;5/50HPF</td>
</tr>
<tr>
<td>Malignant</td>
<td>Any &gt;5/50HPF</td>
</tr>
</tbody>
</table>

STUMP (Stromal Tumors of Uncertain Malignant Potential) is the term used by pathologists to describe a neoplasm when they are unable to distinguish a benign from a malignant tumor.

The pathologist's report in our case was also of a tumor of uncertain malignant potential. This tumor had number of mitosis <5/50HPF and a size of >5cm, placing it in borderline category.

The behaviour of the tumor can be confirmed by various immunohistochemical staining for actin, desmin, vimontin, chromogranin A, C, etc.; 4,5,6,7,8

Clinical presentation of the patients is variable. The common symptoms are:

- Vague non-specific abdominal pain.
- GI tract bleeding which is acute and massive.
- Vomiting which is due to increased hCG production.
- Features of intestinal obstruction and perforation are rare.

This patient had no pain and vomiting. He only had acute and massive bleeding per rectum.

The commonest signs are:

- Pallor.
- Palpable mass; as was found in this reputed case.

The investigations normally required are:

- Blood complete.
- Upper GI endoscopy and biopsy (which is most of the time inconclusive because the tumor is extramural; as it was in our case).
- Ultrasound abdomen showing its extent and spread.
- Contrast studies are rarely required.

The Treatment Principles are:

- Surgery is the mainstay of treatment, involving resection of the tumor with regional lymph nodes.
- There is no role of extended lymphadenectomy.
- There is no role of conventional radio- or chemo-therapy except in metastatic disease.
- The recently developed drug (Gilvec) is said to be effective in stromal tumors of gastrointestinal tract.
- Transcatheter embolization of the jejunal stromal tumors presenting with haematochezia. We did not have the facility available otherwise it could have been tested.

In patients presenting with melena (haematochezia), the possibility of stromal tumors should be kept in mind. Post-surgical follow-up of these patients is very important because of the unpredictable behavior of the tumor. The facility of catheter embolization can be life saving in these cases.

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