Clinics in Surgery

Case Report
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Complete Large Bowel Obstruction by a Rare Pelvic Mass

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Abstract

Background: Retroperitonialfibromatosis are extremely rare. We present a case of a big mass in the true pelvis causing complete large bowel obstruction in a 59 years male.

Case Summary: A 59 years old male patient presented with 4 days history of colicky abdominal pain and distension, nausea, vomiting with absolute constipation. Plain abdominal X-ray showed greatly distended colon with air-fluid levels. Abdominal CT-scan revieled complete large bowel obstruction due to external compression and complete occlusion of the rectum by a big well circumscribed mass in the presacral region, occupying the whole true pelvis. The patient underwent emergency laparotomy and a left loop colostomy to relieve the obstruction. Subsequent MRI study revealed a well encapsulated deep supralevator pelvic mass filling the presacral concavity of 13 x10 x 8 cm, causing complete collapse and obstruction of the rectum. The radiologic features suggested a GIST or mesenchymal tumour.

During laparotomy, the mass was snuggly filling the true pelvis and was not possible to deliver either from the perineum or the abdominal. After several attempts, it was delivered intact trans-abdominally by a using baby "delivery forceps". The patient had an uneventful recovery and his colostomy was later closed. Histopathology showed benign retroperitoneal fibromatosis.

Conclusion: In the presence of complete bowel obstruction, the priority in management is first to vent the bowel and relieve the obstruction. Following that, the obstructed mass should be investigated and later excised. Much pathology can present as solid presacral masses like lipoma/liposarcoma, leiomyoma/leiomyosarcoma, fibroma/fibrosarcoma, Desmoid tumors, ganglioneuromas, paragangliomas, and lymphoma. Preoperative diagnosis may be possible by fine needle aspiration cytology or core biopsy.

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Introduction

Retroperitonialfibromatosis are extremely rare. We present a caseof a big mass in the true pelvis causing complete large bowelobstruction in a 59 years male.

Case Presentation

A 59 years old male patient presented with 4 days history of colickyabdominal pain, distension, nausea, vomiting and absolute constipation. Plain abdominal X-ray showed greatly distended colon with air-fluid levels. Abdominal CT-scan revealed complete large bowel obstruction due to external compression and complete occlusion of the rectum by a big well circumscribed mass in the presacral region, occupying the whole true pelvis (Figure 1). The patient underwent emergency laparotomy and a left loop colostomy to relieve the obstruction. Subsequent MRI study revealed a well encapsulated deep supralevator pelvic mass filling the presacral concavity of 13 x10 x 8 cm, within the true pelvis causing complete collapse and obstruction of the rectum. The radiologic features suggested a GIST or mesenchymal tumour (Figure 2). During laparotomy, the mass was snuggly filling the true pelvis and was not possible to deliver either from the perineal or the abdominal approach. After several attempts, it was delivered intact trans-abdominally by a using baby "delivery forceps" (Figure 3). The patient had an uneventful recovery and his colostomy was later closed.Histopathology showed benign retroperitoneal fibromatosis (Figure 4).

Discussion

Fibromatosis is a heterogeneous group of mesenchymal tumors which has histopathological picture characterized by monoclonal proliferation of fibroblasts and myofibroplasts with

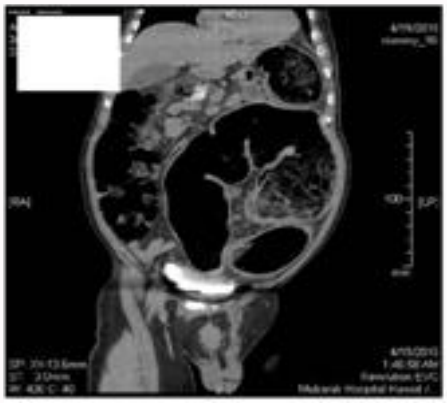

Figure 1: Complete occlusion of the rectum by a big well circumscribed mass in the presacral region.

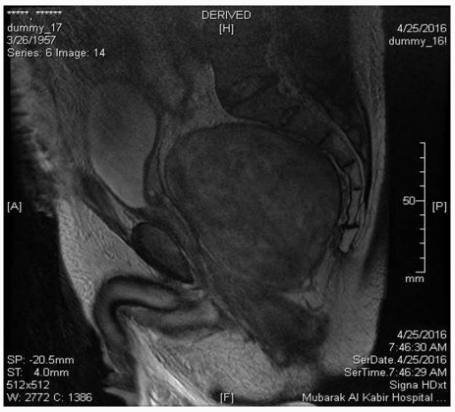

Figure 2: The radiologic features suggested a GIST or mesenchymal tumour.

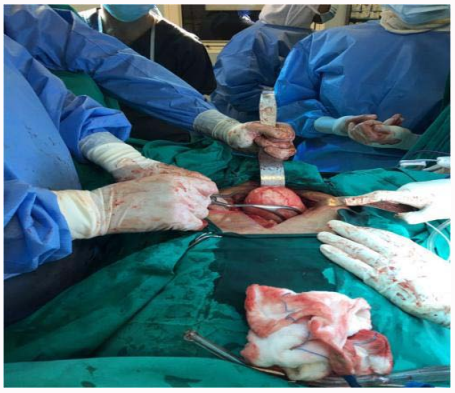

Figure 3: Delivery of the tumour with "baby delivery forceps".

production of intracellular collagen [1].They are rare, slowly growing neoplasms. They have the propensity to locally infiltrate and the tendency to recur in 39-79% of the cases. Fibromatosis arising in the retroperitonum are extremely rare and most of the data in the literature are from isolated case reports [2]. In a large study of 189 cases of fibromatosis over 30 years, only eight [3]. (4%) were located in either retroperitonum or the mesentery It is most commonly seen in the third and fourth decade of life but may occur in any age [4]. The presentation of the tumor depends on the location and the size, it can be in the retroperitoneum causing intestinal obstruction like in our case, ureteric obstruction or nerve compression and if infiltrates the mesentery of the bowel; can result in bowel ischemia. There are many modalities to evaluate the fibromatosis but MRI is the standard of care to evaluate size, location and infiltration of the surrounding structures. Computerized tomography can be used for evaluation of fibromatosis in case of emergency (like our case) to assess the size and location of the tumor. Core biopsy can be used to diagnose the fibromatosis and to exclude other diagnoses like lymphoma, GIST and sarcoma. The standard treatment of fibromatosis is complete surgical resection of the tumor with safety margins.

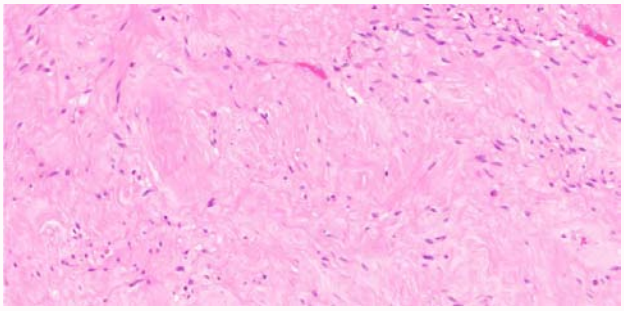

Figure 4: Histpathology: shows fascicles of spindle cells separated by collagen. The cells are bland with rare mitoses. No necrosis present. Features consistent with fibromatosis.

Conclusion

The treatment of primary and recurrent fibromatosis is resection with safety margin. Long-term follow up is important to discover any recurrence.

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