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Rhabdoid cavitated adenocarcinoma in the jejunum, an exceptional case by enteroscopy

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Dear Editor,

We have read the article published by Abdulkader I et al. (1), which described two cases of a rhabdoid tumor of the small bowel diagnosed by surgery. We present a similar case in the jejunum diagnosed by double balloon enteroscopy (DBE).

Case report

We present the case of a 64-year-old patient with multifactorial anemia and transfusional requirements and a flat lesion of 2 cm in the colon, which showed undifferentiated adenocarcinoma on histopathological analysis. The computed tomography (CT) identified a large mass dependent on the small bowel and the positron emission tomography-computed tomography (PET-CT) showed an accumulation in the jejunum with mesenteric implants and in both adrenal glands. The oral DBE confirmed a large cavitated mass in the jejunum with necrotic and ulcerous areas, which presented mild but persistent oozing bleeding (Fig. 1A); biopsies were taken. The intracavitary retroversion of the enteroscope was necessary to identify the "out coming" of the cavitated mass. The histological review of all biopsy samples was consistent with undifferentiated rhabdoid adenocarcinoma (vimentin and cytokeratin [CKae1-be3]) (Fig. 1B), excluding gastrointestinal stromal tumor (GIST) (as the injury seemed) or a neural origin. The patient was treated with chemotherapy.

Discussion

Undifferentiated rhabdoid carcinoma in the small bowel is exceptional, thus this phenotype is highly aggressive with a poor prognosis (1,2). A recent systematic review (2) reported eleven cases at this location, almost the half of them in the jejunum. This case affected adjoining organs including the colon, with multiorgan remote metastases, such as the case presented by Abdulkader I et al. Endoscopically, a large tumor cavitated in the jejunum is also a rarity, which has been described in eccentric GIST (4). There are no previous publications via flexible enteroscopy. We think that DBE is an opportunity to achieve a preoperative diagnosis, which would be indicated in small bowel tumors due to their different management depending on the anatomopathological study.

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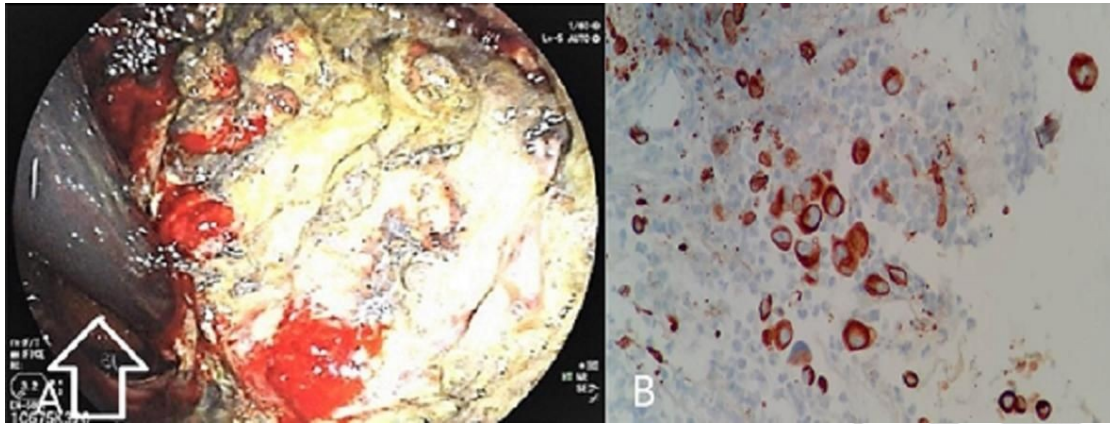


Fig. 1. A. Enteroscope (white arrow) accessing the cavitated mass in retroversion. B. Immunohistochemistry of biopsies of the small bowel mass. Polygonal atypical cells with eccentric nuclei and strong and diffuse positivity for vimentin and cytokeratins.