

## CASE REPORT

**Surgical Relief Of Obstructive Jaundice And Persistent Epigastric Pain In A Patient With Huge Retroperitoneal Tumour: A Case Presentation.**<sup>1</sup>Oguntola A. S<sup>1</sup>Adeoti M. L, <sup>2</sup>Bello T. O, <sup>3</sup>Ojemakinde K. A<sup>4</sup>Mabayoje V. O<sup>1</sup>Department of Surgery, <sup>2</sup>Radiology, <sup>3</sup>Morbid Anatomy / Histopathology, <sup>4</sup>Hematology. Ladoko Akintola Teaching Hospital Osogbo, Nigeria.

Correspondence to: Oguntola A.S.

e-mail: asoguntola@yahoo.com

**Abstract**

A 40 year old trader presented with a 2 week history of colicky upper abdominal pain and later developed jaundice.

Clinically the patient was acutely ill, febrile, dehydrated and in pain. Examination revealed an ill defined tender epigastric and central abdominal mass which with ultrasound and CAT scan was thought to be pancreatic. Persistent pain and rapidly developing jaundice compelled a diagnostic laparotomy which revealed diffuse large Beta cell Non Hodgkins lymphoma. The pain and jaundice rapidly resolved after surgery and the tumor responded well to chemotherapy. The case is reported to point attention to the diagnostic as well as the therapeutic benefit of laparotomy in management of this kind of case.

**Key words** obstructive jaundice, persistent pain, retroperitoneal mass, surgical relief.

**Introduction**

Primary retroperitoneal tumours are rare but majority tend to present when they have invaded adjacent structures and reached considerable sizes thus presenting with protean features. Among these are persistent severe epigastric pain and increasing jaundice which may pose diagnostic and treatment dilemma.

**Case Presentation**

A 40 year old male trader presented with 2 week history of colicky upper abdominal pain, which was of insidious onset, aggravated by meals and lying supine. Relieving factors included sitting up and ingestion of antacids. There was associated anorexia and constipation but no cough, chest pain, weight loss, fever, nor any swelling in any part of the body. There was no history of cigarette smoking or chronic

alcohol or herbal intake.

He was found to be acutely ill looking, dehydrated, febrile, anicteric, and had no peripheral lymphadenopathy. Vital signs were essentially normal. There was generalized vague tenderness in the epigastrium and the central abdomen, with a vague but palpable mass. Examination of the external genitalia and rectum revealed normal findings. An impression of Subacute pancreatitis with pseudocysts was made and he was placed on intravenous fluids, parenteral analgesics and ciprofloxacin.

Abdominal Ultrasound revealed a 12.1 x 9.2 cm, ill defined mass with lobulated outline, which could not be differentiated from the pancreas; it was made up of low medium level echo with multiple rounded hypoechoic foci; the widest diameter of the common bile duct was 8.9mm and the gall bladder was only mildly distended. The sonologist's impression was Mucinous cystadenoma of the pancreas, to rule out Pseudocyst. Haematological parameters, serum electrolytes and urea were within normal limits. The abdominal pain persisted and jaundice developed

while on admission, and biological investigation revealed conjugated hyperbilirubinaemia of 100  $\mu$ mol/L clotting profile of International Normalized Ratio of 1.05. Chest X-ray showed no mediastinal mass.

Contrast enhanced abdominal CAT Scan revealed enlarged pancreas with ill - defined outlines of the body and head, infiltration of surrounding fat, Gerota fascia and the walls of surrounding bowels resulting in marked thickening of the bowel walls. A lobulated large mass was seen extending posteriorly and inferiorly indistinguishable from the pancreas. It encases the great vessels and had some hypo-dense areas within it, extending below the level of the kidneys with no definite enhancement. Kidneys, liver and spleen were found to be normal (fig 1&2).

An impression of acute pancreatitis in phlegmous, to rule out lymphomatous infiltration of the pancreas was made.

He finally had diagnostic Laparotomy two weeks after admission on account of persistent abdominal pain and progressive jaundice. Findings included: (i). retroperitoneal mass in the root of small bowel mesentery; measuring 24cm x 12cm, extending into the supracolic compartment involving the Pancreas, and containing soft greyish fleshy tissue and some altered blood. (ii). multiple mesenteric lymph node enlargement. (iii). Greyish nodule on the jejunum (2x3cm) approximately about 40cm from the ligament of treitz. (iv). The stomach, spleen, liver and colon were grossly normal and the gall bladder was just mildly distended. The parietal peritoneum over the mass was incised longitudinally (~12cm) and incisional biopsy was done, the raw surface was then covered by an omental patch to minimize oozing of blood. The postoperative condition was uneventful, pain and jaundice disappeared within four (4) days, (total bilirubin came down to 31 $\mu$ mol/L) and the general condition of the patient rapidly improved. Scrotal ultrasound showed normal findings. Histology report of the mass and lymphnodes revealed diffuse large Beta cell Non-HODGKINS lymphoma. He was subsequently co-managed with the haematologist using Cyclophosphamide, Vincristine, Adriamycin and Prednisolone. He was discharged home two weeks after Laparotomy to continue treatment as an outpatient. The mass was almost not palpable after about two months postoperative management and abdominal ultrasound showed a remarkable reduction in the size of the tumour.

**Discussion**

Retroperitoneal tumours(RT) are usually locally aggressive. Between 0.3-3% of RT are primary tumours, 60-80% of which are malignant and 75% are of mesodermal origin. Included in the mesodermally derived tumours are those arising from adipose tissue, muscles, connective tissues, blood vessels and lymphatic structures<sup>(1)</sup>. They are usually painless and not commonly associated with jaundice. The constitutional symptoms of fever, weight loss, night sweating was also not found in this patient to give a clue to lymphoma.

The incongruent results obtained from ultrasound and CT scan with persistent severe pain and jaundice necessitated a diagnostic laparotomy. The operative procedure adopted was not detailed enough to be

equated with a staging laparotomy but rather was that of a biopsy of the huge retroperitoneal mass through a long longitudinal incision made over the whole length of the mass. It was very helpful in abating the severe and persistent pain and jaundice. It is presumed that decompression of the retro peritoneum would have reduced pressure on the nerve roots and the common bile duct. The surgeon's role in the treatment of Non - Hodgkin's lymphoma (NHL) differs from his role in the treatment of Hodgkin lymphoma (HL). Whereas the role of staging laparotomy occasionally is controversial in HL, it plays practically no role in the NHL. <sup>(2)</sup> Most extranodal lymphomas are NHL; these frequently are of surgical importance particularly when they arise from the gastrointestinal tract <sup>(3)</sup>. Histological diagnosis in this patient could only have been achieved after the exploratory laparotomy, since there were no peripheral nodes to biopsy. However a CAT Scan guided needle biopsy may have been useful.

Pancreatic lymphoma is a rare presentation of extra nodal lymphoma, constituting about 0.2% to 4.9% of malignant pancreatic lesions and about 2% of all NHL. <sup>(3)</sup>. Preoperative pathologic diagnosis could be made using fine needle aspiration cytology but definitive diagnosis often requires laparotomy. Biliary decompression may also be considered at the time of diagnostic laparotomy, this could be accomplished by carrying out Cholecysto-Jejunostomy.

Our patient responded with progressive remission of the tumour on multiagent chemotherapy during admission and subsequently. This is in keeping with the experience of Webb and colleagues <sup>(4)</sup>. The histologic type, diffused large Beta cell Lymphoma, is regarded as an intermediate grade along with the diffuse small cleaved cell, diffuse mixed cell and follicular large cell in the Working Formulation Grading of Non Hodgkin's lymphoma by the National Institutes of Health <sup>(2)</sup>. It constitutes a good prognosis to our patient as could be inferred from the fairly rapid remission of the tumour and symptoms.

**Conclusion**

Retroperitoneal decompression through a long longitudinal posterior peritoneal incision was useful in our patient with huge retroperitoneal tumour associated with persistent severe pain and progressive jaundice. This cannot be a routine procedure but can be considered if a pancreatic or retroperitoneal mass is enormous and associated

pain and/or jaundice are not responding to moderate ceiling analgesics and multi agent chemotherapy early enough especially in a low resource setting.

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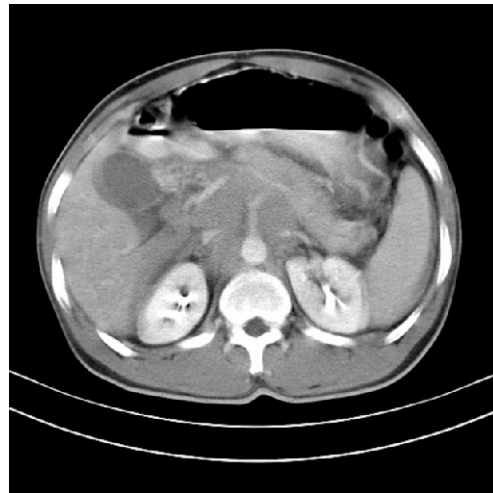


Fig I. CT section showing an hypodense solid mass arising from the region of the head of the pancreas, note the encasing of the abdominal aorta

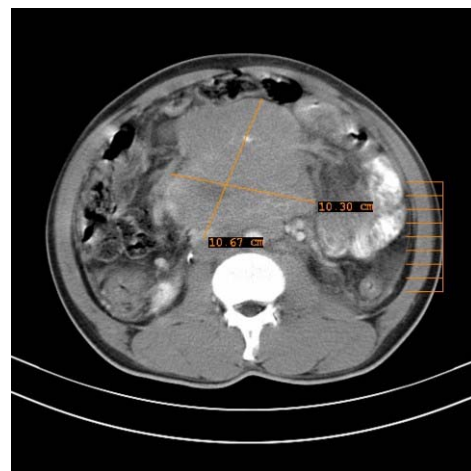


Fig II. CT axial cuts demonstrating the extensive nature of the mass, note measurements of the mass at its widest diameters

CASE REPORT

**Psoriatic Arthropathy In A Black African A Case Report**

Akintayo Oguntola,

Rheumatology Unit. Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State.

Correspondence to: e-mail- oguntolasa@yahoo.com, 08035534449

**Abstract**

*We report the case of a 40 year old Military Officer with psoriatic skin lesions who developed arthropathy a complication said to be rare in the Black race. He was successfully managed with psoralen and methotrexate and the case is reported to increase the awareness of practitioners to the occurrence of the complication in blacks*

**Key Words:** Psoriasis, Black, HLA antigen, Joint deformity, Methotrexate.

**Introduction**

Psoriasis is a chronic recurrent disease of variable severity that affects between 1-4% of the population<sup>1</sup>. It is associated with an inflammatory sero-negative arthritis- Psoriatic arthritis in approximately 5-7% of psoriatic patients<sup>1</sup>. The key histological features of psoriasis are epidermal keratinocyte hypoproliferation, dermal vascularity, and an inflammatory infiltrate<sup>2</sup>.

Over the last few years, the role of some genes, for example HLA-CW6 and the role of the immune system in the development of psoriasis have become more defined<sup>3</sup>. It has been demonstrated that innate immunity plays a key role in the development of psoriasis, especially through the production of cytokines, the most important of which is TNF alpha<sup>3</sup>. Environmental triggers known to induce psoriasis include beta- haemolytic streptococcal infection, Human Immunodeficiency Virus (HIV), and drugs such as beta-blockers and stress.

Although rarely life-threatening, psoriasis causes considerable psychological disability and impairment of quality of life for those it afflicts. Most cases present before the age of forty years (type 1 psoriasis) with a second peak of onset between 55 and 60 years (type 11 psoriasis). Clinically, there is little to distinguish type 1 from type 11 disease. As a general observation, type 1 psoriasis is familiar, severe and has a strong association with HLA-CW6<sup>4</sup>. Type 11 psoriasis is neither familiar nor associated with HLA-CW6<sup>4</sup>. Psoriasis is associated

with psoriatic arthropathy which is classified as spondyloarthritides (SPA)<sup>5</sup>. Psoriatic spondylitis is associated with HLA- B27.

The treatment modalities include non-steroidal anti-inflammatory drugs (NSAIDS) and topical steroids. Disease modifying agents, such as methotrexate and sulfasalazine are used in active joint disease not responsive to NSAIDS. Newer classes of drugs are leflunomide and anti-TNF alpha agents<sup>6</sup>.

**Case report**

A 40 year old military officer presented with joint swelling involving the distal and proximal interphalangeal joints of the hands, the wrists and the ankles of two years duration. The swelling of the wrist joints was associated with early morning stiffness of the fingers of less than ten minutes duration. There were no associated subcutaneous nodules.

He however admitted to the presence of certain skin lesions on his back dated to six years prior to the onset of the arthritis. He had been on various skin ointments for the skin lesions and several NSAIDS (non-steroidal anti-inflammatory drug) for the arthritis without any significant improvement.

When examined, he had psoriatic plaques on his back (fig 1). There were however no nail changes. The medial four fingers bilaterally were tender with flexor deformity of the distal interphalangeal joints (fig 2). He also had tender and swollen wrists (fig 2) and bilateral tenderness in the ankles. There was no tenderness at the tendon insertions and the sacroiliac joints. Other systems were essentially normal.

A diagnosis of psoriatic arthritis was made. Laboratory results revealed normal full blood count with elevated ESR (55MM/HR), negative rheumatoid factor and anti-nuclear antibody. HLA antibody was however not done. No radiological changes were noted.

The patient was placed on NSAIDS, methotrexate, and psoralen. He made significant improvement in both skin and joint manifestations. He is still presently attending the out-patient clinic for follow-up.