INTRODUCTION

Should one proceed to a diagnostic laparotomy in a case of advanced malignancy in the absence of overwhelming clinical symptoms? The case reported will illustrate the necessity to do so, particularly in the light of confusing symptoms and difficult medical imaging.

CASE REPORT

A 66-year-old male patient was referred to the urological outpatient department with symptoms of frequency, nocturia (10 x per night) and poor urinary flow. There was no evidence of macroscopic haematuria. The patient also complained of constipation, weight loss of 10kg and episodes of sweating.

On examination, he was found to be dehydrated and apyrexial with a pulse of 127/min and BP 120/80. Abdominal examination revealed a tender mass in the left iliac fossa and rectal examination revealed hard faeces and a normal prostate gland. The patient was admitted and the following blood results were obtained: Hb 14.1, WCC 17.6, platelets 776, urea 10, K 3.7, Na 137 and Crea 94. He was then referred to the general surgical department. An abdominal ultrasound scan (Fig 1) revealed a mass in the right kidney (solid and likely to be a tumour), a small cyst in the left kidney and a mass in the left iliac fossa with typical features of a large bowel tumour.

Fig 1 A solid mass in the right kidney detected at ultrasound scanning

Fig 2 Barium enema. The colon is normal but a mass separates the sigmoid and descending colon.

Fig 3a CT showing a solid irregular mass in the right kidney
A barium enema (Fig 2) showed some diverticula and a vague impression of a soft tissue mass in the sigmoid colon. CT scan (Figs 3a and b) obtained the same day revealed a solid mass in the right kidney with the appearance of a renal carcinoma, and an extensive solid mass of malignant appearance in the left lower abdomen with no evidence of liver involvement.

In the meantime the patient was rehydrated and transfused two units of blood. He improved clinically and displayed few symptoms. The decision was taken to perform a laparotomy.

At laparotomy, tumour were found at the duodeno-jejunal flexure, between different small bowel loops, at the ileo-caecal junction and in one small bowel loop, causing intussusception. Multiple lymph node involvement was noted and there was a large mass in the right kidney.

The intussusception was reduced and biopsy of the main tumour mass performed. Histology revealed a high grade malignant lymphoma. At this stage the patient was referred to the haematologist. Further staging revealed no bone marrow involvement and the patient is currently receiving three courses of CHOP chemotherapy.

**DISCUSSION**

The case presented shows the importance of a histological diagnosis. It should be noted that 3.5% of all GI malignancies are primary lymphomas. The decision to perform a diagnostic laparotomy despite the fact of extensive non-excisable malignancy in the absence of overwhelming symptoms (ie obstructions) was correct.

According to the literature 45% of all GI lymphomas are highly malignant. Fifty-five percent are within the small intestine with 4% multiple locations. There is also a male predominance and despite widespread involvement they do not cause malabsorption.

**SUMMARY**

Presented here is a case of widespread intra-abdominal malignancy which turned out to be a high grade lymphoma. This is a treatable condition in which chemotherapy gives good results.

**LITERATURE**

General Pathology; Walter Israel; Churchill Livingstone

Muir's Textbook of Pathology; Anderson; Arnold