

GASTROINTESTINAL STROMAL TUMOR: CASE REPORT

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ABSTRACT: Gastrointestinal stromal tumors (GIST) are rarely seen tumors. We reported a case of a 45-year-old male in our institution that appeared with vague pain in the right iliac fossa for 1 year and was determined to have a GIST. We report his development and talk about the current hypotheses of the beginning of these uncommon tumors and recent treatment modalities.

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INTRODUCTION

Gastrointestinal stromal tumors (GISTs) emerge from interstitial cells of Cajal, mesenchymal stromal cells and address 5% of GIT tumors. Group CD117 is a transmembrane receptor protein that is fundamental to separating GIST from other mesenchymal masses (1,2). Extra gastrointestinal stromal tumors (EGISTs) are rare in those below 50 years of age and more common in individuals more than 50 years of age. GIST begins in the mesentery, omentum, and peritoneum (3, 4).

CASE REPORT

We demonstrated a rare case report of a 45-year-old male. The patient was introduced to our institute with a 1-year history of rising vague pain and distension of the abdomen. The patient had no history of obstructive features, bleeding PR, distorted bowel habits, weight loss, nausea, or vomiting. He had no noteworthy past clinical or surgical history. There was a palpable mass in the right iliac fossa which was firm mobile and slightly tender rest of the abdominal assessment was unremarkable.

Baseline Workup was regular except for complete blood count (CBC) which showed hemoglobin (Hb) of 8 mg/dl, ultrasound showed a mass in the right iliac fossa. Computed tomography (CT)

A scan was then carried out which confirmed the diagnosis. Abdominal and pelvis computed tomography (CT) reported an enormous mass transcending cystic with more intersecting strong improving parts (Figure 1).

CT of the mid-region and pelvis announced a huge cystic mass in the right iliac fossa was identified in the laparotomy (Figure 2). The tumor markers were regular separately from a CA 125 219 (regular<35). A huge mass was resected from the right iliac fossa that was adherent to the colon (Figure 3). An exploratory Laparotomy was done for the resection of the mass and end-to-end anastomosis was done. Quarterly follow-up was arranged with additional abdominal CT and imatinib treatment with additional assessment for 1 year later.

DISCUSSION

GISTs essential mesenteric are EGISTs which are uncommon and as of now, there are 2 speculations regarding their starting point. In light of immunophenotype and histology GISTs and EGISTs are indistinguishable, thus EGISTs may address GISTs that are isolated from GIT or essential developments from the omentum or mesentery (5,6). EGISTs have not only been seen in the omentum but have additionally been seen in the abdominal wall, mesothelium, pleura, and pancreas.

Cyst formation, mitotic rate $>2/50$ hpfs, necrosis, Ki 67 $>10\%$, and augmented cellularity show more aggressive behavior (7,8). A Classification system has been developed by the National Institute of Health for the malignant risk in GISTs. It went from exceptionally generally safe to high hazard and depended on tumor size and mitotic count. [8,9] Right now, the backbone of EGISTs treatment is a bloc resection with imatinib (10-12).

It has been evaluated the long-term survival by combined adjuvant chemotherapy (hydroxy camptothecin, epirubicin, and cyclophosphamide), neoadjuvant

chemotherapy, and surgery (13) that may be helpful in cases where there is resistance to imatinib. The recurrence rate is reported 50% following *en bloc* resection within 2 years (14) More advanced studies into these uncommon tumors are obligatory.

CONFLICT OF INTEREST

There is no conflict of interest. The images are published with the permission of the patient and are not published and discussed anywhere. The corresponding author has not received any scholarship. The contributing co-author agrees with the contents.

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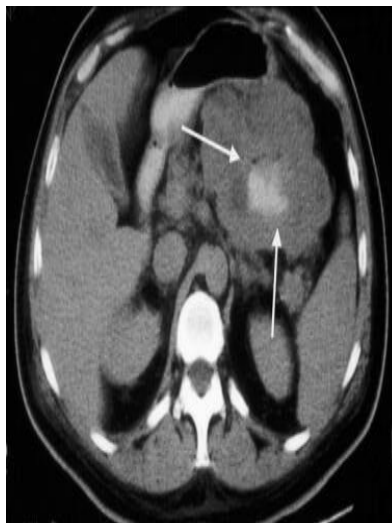


Figure 1: CT scan of abdomen showing a well circumscribed mass of small bowel involving proximal ileum

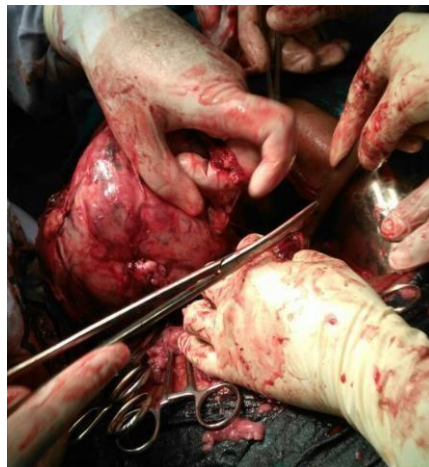
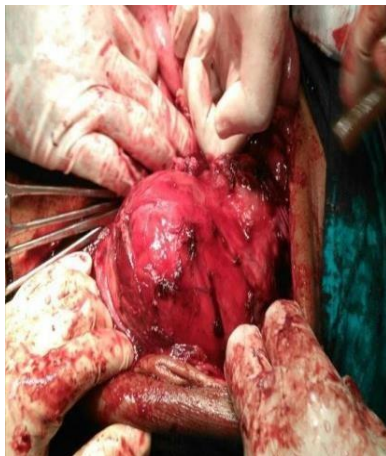


Figure 2: Operative images of proximal ileum GIST

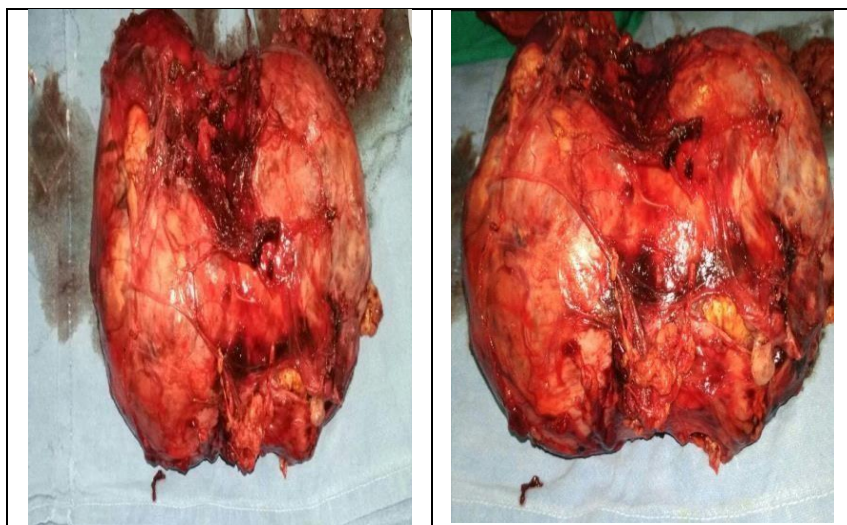


Figure 3: Excised GIST from proximal ileum