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Adenocarcinoma of the Small Bowel: A Case Report

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Abstract **Case Report**

Malignant tumors of the small intestine are rare, accounting for between 1 and 6% of tumors of the digestive tract. Adenocarcinoma is the most common histologic subtype, accounting for approximately 35% to 45% of all tumors. It can occur sporadically, or in association with genetic diseases or chronic inflammatory bowel disease. Because the small intestine is relatively inaccessible by endoscopy and the absence of specific clinical signs, diagnosis is difficult and often delayed for several months after the onset of symptoms. The role of adjuvant treatment after R0 surgical resection is not yet clear, given the paucity of series reported in the literature. The combination of capecitabine and oxalliplatin is highly active, with a median overall survival of 15 months in advanced and metastatic patients. Through this article, we have been able to describe the clinical and para-clinical aspects and the different therapeutic modalities.
Keywords: Grele – adenocarcinoma – surgery – metastasis – chemotherapy.

INTRODUCTION

Small bowel adenocarcinomas are 50 times less common than colon adenocarcinomas [1]. More than 50% are diagnosed in the duodenum, the proximal jejunum and the ampulla of Vater being the most frequent sites [2]. The most important risk factor for small bowel adenocarcinoma is the existence of a pre-existing adenoma, either isolated or multiple in association with one of multiple polyposis syndromes [3]. Adenocarcinomas, especially those of the duodenum, become symptomatic long before other small bowel tumors, allowing early detection and therapeutic intervention. However, most small bowel carcinomas are discovered at a metastatic stage [4]. In the absence of any significant prospective series published. Small bowel adenocarcinomas are usually therapeutically assimilated to colon cancer; curative treatment is surgical. Adjuvant chemotherapy is often offered as in colon cancers depending on risk factors. Overall 5-year survival is 30.5%, with a median of 19.7 months [5]. In this article, we report an observation of small adenocarcinoma collected at the visceral surgery department B of CHU HASSAN II in Fez, through which we will discuss current therapeutic attitudes.

OBSERVATION

Mr K.M aged 60 years, cholecystectomies 2 years ago by a right subcostal median. Admitted to the emergency room for an occlusive syndrome 5 days ago with vomiting, on examination; stable patient, distended abdomen, tympanic membrane Abdominal CT revealed the presence of slime distension upstream of slime mass.

The surgical exploration did not objectify carcinosis the procedure consisted in a resection of the small mass with anastomosis. The post-operative consequences were simple.

Pathological examination in favor of a moderately differentiated ADK, tumor classified as PT3N0, with monitoring as a decision.

DISCUSSION

Small bowel adenocarcinomas are 50 times less common than colon cancer [1]. Compared with other gastrointestinal tumors, knowledge of the natural history of these cancers is limited and this is also due to their rarity. Than the variety of different types of tumors encountered [6]. The most common symptoms found in small bowel adenocarcinoma are: abdominal pain (60%), overt or occult digestive bleeding (50%), anemia (50%), occlusion picture (30%) and deterioration of the general condition [7]. Certain hereditary syndromes, certain inflammatory alterations of the small intestine are associated with an increased incidence of adenocarcinomas of the small intestine such as: familial

adenomatous polyposis [8], juvenile familial polyposis, sporadic adenomas , Crohn's disease [9], dietary factors such as tea, sugar, coffee or aromatic amino acids could also predispose to the development of small bowel adenocarcinomas [10], Adenocarcinomas are uncommon in clinical practice, seen the absence of specific clinical signs, and very often it is the emergency laparotomy imposed by an acute accident which makes it possible to discover it, or they are diagnosed already at the stage of metastasis. The diagnosis can be particularly difficult for adenocarcinomas of the ileum when they occur in the context of Crohn's disease because the tumor clinically simulates an increase in the inflammatory process of the disease or fibrous stenosis [11].The diagnosis of tumors located on other segments of the small intestine is typically made either by transit of the small bowel in double contrast, or more often by enteroscopy [12, 13]. The barium enema, which visualizes the Bauhin valve and terminal ileum, may be useful in the diagnosis of tumors located in this segment of the intestine. The presence of metastases can be assessed by thoracic-abdominal-pelvic CT.

Surgery is the treatment of choice and the only potentially curative therapeutic modality. Duodenal tumors may require cephaloduodenopancreatectomy; in other locations, simple resection of the affected segment and mesentery with lymph node dissection. Small adenocarcinomas, especially polyploid lesions with infiltration limited to the mucosa or submucosa, can sometimes be treated by endoscopic resection [14].

Currently, the use of adjuvant chemotherapy after curative surgical treatment is not consensual. The various studies carried out on the use of adjuvant chemotherapy in small bowel adenocarcinoma were intended for groups of patients at high risk of recurrence, considered to have a poor prognosis compared to patients who do not receive adjuvant chemotherapy. Most centers use 5FU-based mono-chemotherapy [5]. Regarding the role of radiotherapy as a component of adjuvant treatment of adenocarcinoma of the duodenum has been studied to a limited extent, in a recent series from Duke University, no difference in overall 5-year survival was observed between patients who have or have not received radiotherapy in combination with 5FU as an adjuvant or neoadjuvant. However, in the subgroup of patients who had a margin of resection negative, overall 5-year survival was 53% in the surgery only group and 83% in the chemo-radiotherapy group [15].

In a metastatic situation, two prospective studies were carried out: A multicenter study conducted by the Eastern Cooperative Oncology Group (ECOG) reported the combination of 5-FU, doxorubicin and mitomycin C (FAM) in 39 patients with adenocarcinoma small intestine or Vater's ampulla.

The overall response rate was 18%, with a median overall survival of 8 months. [16] A second phase II study (CAPOX) evaluated the benefit of the combination of capecitabine and oxaliplatin in 30 patients with metastatic or locally advanced small bowel adenocarcinoma: The overall response rate was 50%, with a median time to 'with progression of 11.3 months and a median overall survival of 20.4 months [17], when administered to patients in good state of performance, CAPOX is well tolerated with a higher response rate in terms of overall survival compared to other regimens in the literature. CAPOX should be considered a new standard for advanced small bowel adenocarcinoma [5].

The prognosis of adenocarcinoma of the small intestine may be improved. The age of the patient, the location of the tumor, its stage and the possibility of having radical oncologic surgery are factors related to survival. Overall 5-year survival is 30.5%, with a median of 19.7 months [18].

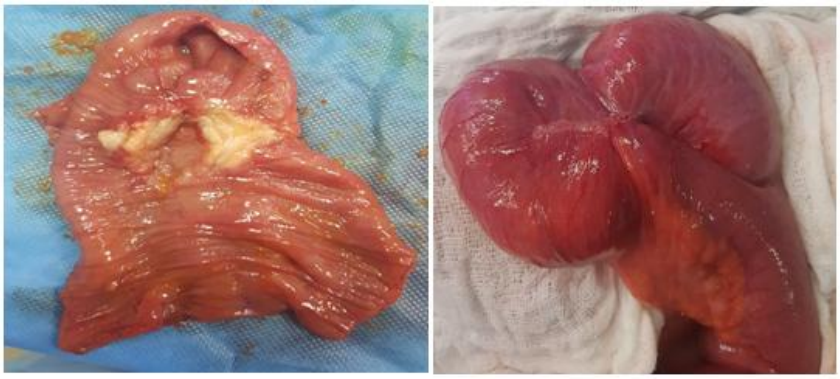

Fig-1□: Adenocarcinoma of the small bowel

CONCLUSION

Adenocarcinomas of the small intestine pose diagnostic problems because of their rarity and the absence of specific clinical signs. They are often operative findings following an acute complication. The basic treatment is surgical; the benefit of adjuvant chemotherapy is not well established given the paucity of prospective and retrospective studies. The standard

currently accepted in the advanced stages is the CAPOX regimen. Their long-term prognosis, which is still reserved, may improve with complementary treatments, hence the need for further studies and to include patients in clinical trials.

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