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Tumoral mass in the left iliac fossa in an elderly woman

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Clinical case: female patient, 69 years old, with a history of HP-positive erosive gastritis and gastric polyposis diagnosed about one year before admission to our unit. At that same time, colonography was performed at a local hospital, which evidenced a defective image of the sigmoid. Further investigation by colonoscopy to be performed in a university hospital was recommended, but the patient had refused.

In the past 6 months the patient ha d gradually developed asthenia, and an outpatient examination revealed iron deficiency anemia, accounted for by the gastritis. The evolution was also marked by self-limiting episodes of diarrhea (4-5 stools a day), pain on the left side and iliac fossa, as well as body weight loss (about 6 kg.).

Physical examination evidenced a pale patient, in a moderately altered nutritional condition, tachycardia. Palpation of the left iliac fossa found a firm tumoral mass, relatively fixed, moderately painful. The rest of the abdominal examination was normal, except the post-appendicectomy scar.

Biological tests performed on admission evidenced mild anemia (Hb = 12,1 g/dl), with normal erythrocytic values and low sideremia (31 micrograms/dl), as well as moderately increased ESR (55 mm at 2 hours).

Ultrasonography was the first imaging examination performed after the admission; it evidenced a non-homogeneous parenchymatous mass, vascularized, 10-11 cm in diameter (fig 1, fig 2). In the center of the tumoral mass an airy image was found, looking like the lumen of a digestive segment (fig 3). The mass continued upwards with the normal image of the descending colon and there was no distention of the loops above the site at the time of the examination. On the anterior and lateral sides the mass was covered by a small collection that continued on a fine trajectory to the posterior side of the abdomen (fig 4).



Fig 1.

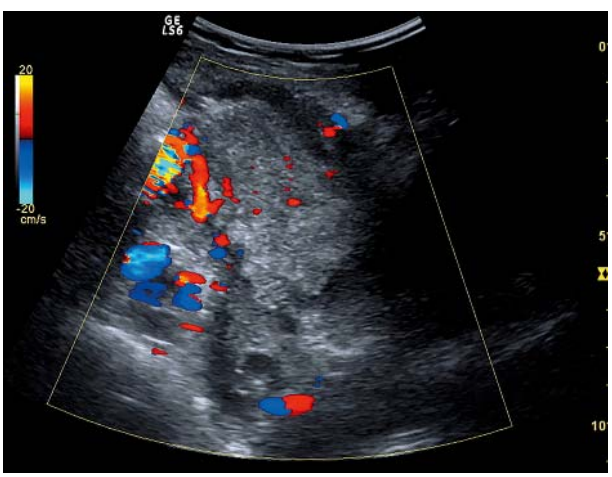


Fig 2.

CT evidenced the same mass, thought to come into contact with the sigmoid colon, which was marked and narrowed, without signs of peritoneal fluid collection. The aspect was considered inconclusive, suggesting

rather an inflammatory process agglutinating certain intestinal loops which it infiltrated and narrowed.

Colonoscopy evidenced a massive obstructive tumour at the level of the sigmoid.

The indication was urgent surgical treatment because of the risk of intestinal occlusion, which in fact happened on the day the patient was transferred to the surgical unit and precipitated the operation.

Questions:

1. What is your ultrasound diagnosis?
2. How do you explain the discrepancy between the colonoscopy and US diagnosis on the one hand and the CT on the other?
3. What is unusual in this case and what is its particular feature?

The answers and the comments can be sent on email medultrasonography@gmail.com.

Answers and comments in the next issue.

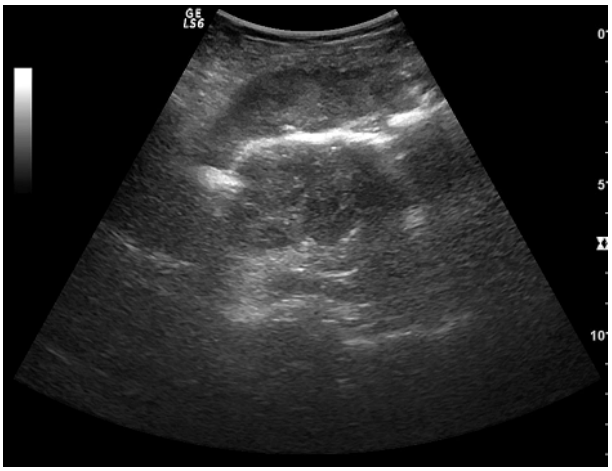


Fig 3.

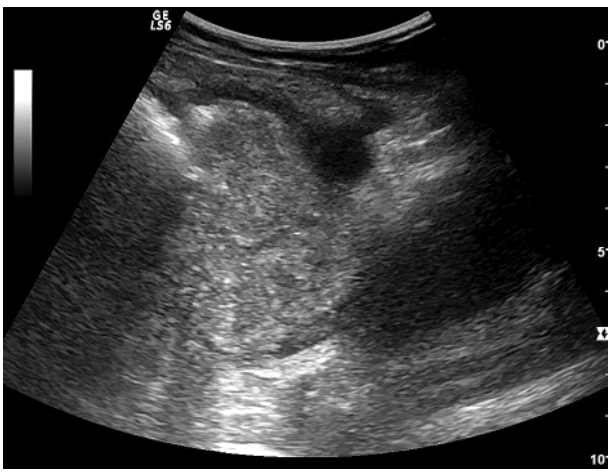


Fig 4.