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Multifocal Intra-abdominal Papillary Adenocarcinoma Presenting with Severe Gastrointestinal Bleeding in a Patient with Serous Endometrial Carcinoma: A Diagnostic Challenge

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ABSTRACT

Introduction: *Small-bowel adenocarcinoma is a rare malignancy that may present with gastrointestinal bleeding and severe anaemia, often with delayed diagnosis because the small bowel is difficult to evaluate using conventional endoscopy. Multifocal intestinal tumours in patients with previous gynaecological malignancy create an additional diagnostic challenge in distinguishing primary from metastatic disease.*

Case Presentation: *A 70-year-old woman with recently diagnosed serous endometrial carcinoma presented with four months of recurrent melena, profound anaemia (haemoglobin 4.4 g/dL), weight loss and weakness. Upper gastrointestinal endoscopy and colonoscopy failed to identify the bleeding source. Computed tomography revealed a large exophytic intra-abdominal mass and additional pelvic and lymph-node lesions, initially considered suggestive of a gastrointestinal stromal tumour or other mesenchymal neoplasm. Exploratory laparotomy demonstrated three intra-abdominal tumours, including a large proximal jejunal mass adherent to the colon, a second inter-loop intestinal tumour and a third pelvic tumour was adherent to the urinary bladder and anterior abdominal wall. Segmental jejunal resection and left hemicolectomy were performed. Histopathology revealed papillary adenocarcinoma. Immunohistochemical evaluation was not performed because of the patient's rapid postoperative deterioration. She subsequently developed persistent hypoxaemia and died postoperatively.*

Conclusion: *Small-bowel malignancy should be considered in patients with recurrent melena and severe anaemia despite negative conventional endoscopy. Multifocal intestinal tumours in patients with previous endometrial carcinoma require careful consideration of both primary small-bowel adenocarcinoma and metastatic disease. Histopathology, supported by appropriate immunohistochemistry, is essential for establishing tumour origin and guiding management.*

Keywords: *Gastrointestinal bleeding; Multifocal intra-abdominal tumours; Papillary adenocarcinoma; Small-bowel adenocarcinoma; Small-bowel metastasis.*

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Introduction

Small-bowel adenocarcinoma is a rare gastrointestinal malignancy that often presents with non-specific symptoms, including abdominal pain, anemia, gastrointestinal bleeding, and intestinal obstruction, resulting in delayed diagnosis {1,2}. Because the small bowel is relatively inaccessible to conventional endoscopy, bleeding from small-bowel tumours may remain unexplained despite negative upper and lower gastrointestinal investigations {3}.

Papillary adenocarcinoma is an uncommon histological pattern of small-intestinal adenocarcinoma and may be difficult to distinguish from other exophytic intra-abdominal tumours on imaging alone {1,2}. The diagnostic challenge is greater in patients with a previous malignancy, particularly high-grade serous endometrial carcinoma, which is an aggressive tumour with a recognized risk of extra-pelvic recurrence {4}. Although gastrointestinal metastasis from endometrial carcinoma is rare, it may involve the small bowel and present with significant gastrointestinal complications {4}.

We report a rare case of multifocal intra-abdominal papillary adenocarcinoma presenting with severe gastrointestinal bleeding in a patient with previous serous endometrial carcinoma, highlighting the diagnostic difficulties in distinguishing a primary small-bowel malignancy from metastatic disease.

Case Presentation

A 70-year-old woman presented with a four-month history of recurrent melena and a two-month history of productive cough. The melena occurred 2–3 times daily and was associated with epigastric pain radiating to the back, progressive dizziness, generalized weakness, easy fatigability, reduced exercise tolerance, weight loss and poor appetite. There was no haematemesis or fresh rectal bleeding. She subsequently developed intermittent behavioural changes, restlessness and confusion. The cough was productive, occasionally blood-streaked, and associated with chest pain, without fever, night sweats or dyspnoea.

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She had a history of peptic ulcer disease treated with rabeprazole and occasional NSAID use. She was also hypertensive on treatment. Four months before presentation, she had undergone total abdominal hysterectomy with bilateral salpingo-oophorectomy for suspected gynaecological malignancy. Histopathology demonstrated serous endometrial carcinoma, with normal ovaries and fallopian tubes. Previous cervical cytology had shown high-grade squamous intraepithelial lesion. Her family history was notable for gastrointestinal malignancy and a daughter who died from abdominal Burkitt lymphoma.

On examination, she was lethargic, restless and markedly pale. Blood pressure was 130/90 mmHg, pulse 83 beats/min, respiratory rate 24/min and oxygen saturation 98% on room air. The abdomen was full but soft, with no tenderness, organomegaly or palpable mass. Digital rectal examination confirmed melena. She was conscious with a GCS of 15/15 and had no focal neurological deficit.

Full blood count demonstrated profound normocytic anaemia, with haemoglobin 4.4 g/dL, PCV 13.7%, RBC count 1.68 × 10^6/μL and MCV 81.5 fL. Platelet and white-cell counts were 345 × 10^3/μL and 7.8 × 10^3/μL, respectively, with an elevated RDW-CV of 16.5%. Faecal occult blood testing was positive.

Upper gastrointestinal endoscopy demonstrated pan-gastritis and a Grade I hiatus hernia. Repeat gastroscopy showed widespread whitish oesophageal patches but no varices or ulceration, while the stomach and duodenum were normal. Colonoscopy revealed altered blood clots throughout the colon, from the rectum to the caecum, without an identifiable bleeding source.

Chest radiography demonstrated widespread bilateral pulmonary opacities suspicious for metastatic disease. CT of the abdomen and pelvis revealed a heterogeneous exophytic mass measuring 12.1 × 7.4 cm in the left flank, adjacent to the splenic flexure and descending colon, with displacement and compression of the colon. A second solid-cystic pelvic mass measuring 6.3 × 4.3 cm and multiple para-aortic and aortocaval lymph nodes were also identified. Multiple pulmonary opacities were noted in the visualized lower thorax. The radiological differential diagnoses included gastrointestinal stromal tumour, mesenteric tumour and leiomyosarcoma.

The patient was resuscitated with oxygen, intravenous fluids, proton-pump inhibitor therapy, antibiotics, and blood transfusion, receiving six units of blood before surgery. Exploratory laparotomy was performed on the eighth day of admission. Extensive intra-abdominal adhesions were encountered. A large tumour measuring approximately 15 × 8 cm was identified approximately 20 cm distal to the ligament of Treitz, with adhesions to the splenic flexure. A second tumour measuring approximately 8 × 3.2 cm was associated with inter-loop bowel tethering and extensive ileal and jejunal adhesions. A third pelvic tumour was adherent to the urinary bladder and anterior abdominal wall. The distal bowel loops were collapsed.

A left hemicolectomy with colo-colic anastomosis and resection of the involved proximal jejunal segment with jejunojejunal anastomosis were performed. She received two units of blood intraoperatively and a further two units postoperatively. Histopathological examination of the resected tumours demonstrated papillary adenocarcinoma.

The immediate postoperative period was initially stable; however, she subsequently developed persistent oxygen desaturation requiring supplemental oxygen. She later died during the postoperative course.

Discussion

Small-bowel adenocarcinoma (SBA) is an uncommon gastrointestinal malignancy and accounts for a small proportion of gastrointestinal cancers. Its diagnosis is frequently delayed because clinical manifestations are nonspecific and conventional upper and lower gastrointestinal endoscopy provides limited access to the small bowel. Patients may present with abdominal pain, gastrointestinal bleeding, anaemia, weight loss or intestinal obstruction {1,5,6}. In the present case, recurrent melena and profound anaemia were the dominant manifestations, while both gastroscopy and colonoscopy failed to identify the bleeding source. Cross-sectional imaging subsequently demonstrated large intra-abdominal masses, initially considered radiologically to represent gastrointestinal stromal tumour (GIST), mesenteric tumour or leiomyosarcoma.

Small-bowel pathology should be considered in patients with persistent or overt gastrointestinal bleeding when conventional upper and lower endoscopy are nondiagnostic. Current guidelines recommend video capsule endoscopy as an important first-line investigation for suspected small-bowel bleeding, with device-assisted enteroscopy providing an opportunity for histological diagnosis and therapy when indicated {7,8}. In this patient, such investigations were not performed before surgery, and the bleeding source was ultimately identified intraoperatively. The large jejunal-associated tumour was considered a likely contributor to the severe gastrointestinal haemorrhage, although the exact mechanism of bleeding could not be established.

Histopathological examination of the resected tumours demonstrated papillary adenocarcinoma, confirming an epithelial malignancy. This finding differed from the preoperative radiological impression of a mesenchymal tumour. Although imaging can characterize tumour location, extent and relationships with adjacent structures, it may not reliably distinguish intestinal adenocarcinoma from other large exophytic intra-abdominal neoplasms {1,5,6}. Definitive diagnosis therefore depends on histopathological examination and, when the primary site is uncertain, appropriate immunohistochemical characterization.

The previous diagnosis of serous endometrial carcinoma introduced an important diagnostic dilemma. Endometrial serous carcinoma is a high-grade histological subtype with a recognized propensity for extrauterine and distant dissemination {9,10}. Although gastrointestinal involvement is uncommon, small-bowel metastasis from endometrial carcinoma has been documented and may present with obstruction, fistulation or other gastrointestinal manifestations {11,12}. The multifocal nature of the abdominal tumours, associated lymphadenopathy and pulmonary lesions in the present patient therefore raise the possibility of metastatic disease. However, the available histology alone cannot establish whether the papillary adenocarcinoma represented a primary intestinal malignancy or metastatic/recurrent endometrial carcinoma. Immunohistochemistry would ordinarily be important in resolving this distinction. Panels incorporating markers such as PAX8, WT1, p53, CK7, CK20, CDX2, and SATB2 can assist in determining Müllerian versus intestinal differentiation, although no single marker should be interpreted in isolation {13-15}. CDX2 supports intestinal differentiation but can occasionally be expressed in non-intestinal malignancies, while SATB2 is useful for assessing lower gastrointestinal differentiation but is not entirely specific for colorectal origin {14,15}.

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In this patient, immunohistochemical evaluation could not be performed because she developed postoperative deterioration and subsequently died. Consequently, the precise origin of the papillary adenocarcinoma remains unresolved and represents a major limitation of this case.

The case also illustrates the diagnostic challenges associated with gastrointestinal malignancies in Nigeria and other resource-constrained settings. Colorectal cancer is increasingly recognized in Nigeria and is frequently diagnosed at an advanced stage {16}. A recent multicentre Nigerian study found that approximately one-third of patients with colorectal cancer presented emergently, with emergency presentation associated with more advanced disease and substantially shorter overall survival {17}. Similarly, Nigerian studies demonstrate that serous carcinoma constitutes an important high-grade subtype of endometrial carcinoma and occurs predominantly among older women {18}. These findings underscore the challenges of diagnosing and managing patients with complex, advanced malignancies where access to capsule endoscopy, device-assisted enteroscopy, molecular investigations and comprehensive immunohistochemistry may be limited.

Surgical exploration was therefore both diagnostic and therapeutic in this patient, permitting resection of the large bleeding-associated intestinal tumours and involved bowel segments. However, the presence of multifocal intra-abdominal tumours, lymphadenopathy and pulmonary abnormalities suggested advanced disseminated malignancy. Her subsequent postoperative death further emphasizes the poor prognosis associated with extensive disease. The principal lesson from this case is that small-bowel malignancy should remain an important consideration in unexplained gastrointestinal bleeding despite negative conventional endoscopy, while the presence of a previous extraintestinal malignancy requires careful consideration of metastatic disease and histopathological confirmation of tumour origin whenever possible.

Conclusion

This case highlights the importance of considering small-bowel malignancy in patients with recurrent melena and severe anemia despite negative upper and lower endoscopy. An exophytic intestinal mass that appears radiologically to be a GIST may represent adenocarcinoma. In patients with a previous high-grade gynaecological malignancy, multifocal intestinal tumours should prompt consideration of metastatic disease, with histopathology and appropriate immunohistochemistry being essential for establishing tumour origin.

Patient Consent: Consent was obtained from the patient's relations for publication of this case report and accompanying images.

Conflict of Interest: The authors declare no conflict of interest.

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