87 year-old female with history of heme(+) stool and jejunal ulcer versus ulcerated mass on capsule endoscopy.

Samantha Lee, MS4
Ryan Joyce, MD
Jejunal adenocarcinoma with regional mesenteric nodal metastases
CT abdomen / pelvis - coronal reconstruction

Apple core jejunal lesion
Two adjacent enlarged mesenteric lymph nodes
Small bowel loop, mildly dilated
Beginning of irregular circumferential mural thickening
Irregular circumferential mural thickening
Irregular circumferential mural thickening
Irregular circumferential mural thickening
Irregular circumferential mural thickening
Irregular circumferential mural thickening
Irregular circumferential mural thickening
Enlarged mesenteric lymph node (1.8 cm)
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Small bowel adenocarcinoma

Epidemiology
• Risk of small bowel cancer 1.8 per 100,000 persons
• Risk factors: age (mean 65), male gender, African American

Etiology
• Microsatellite instability or adenoma sequence
• Genetic predisposition: Hereditary nonpolyposis colorectal cancer syndrome, Familial adenomatous polyposis, Peutz-Jeghers syndrome, among other genetic disorders
• Chronic inflammation, such as in Crohn’s disease

Presentation
• Abdominal pain, nausea, vomiting, weight loss, GI bleeding, obstruction, intussusception
• Stage at presentation: 39% Stage I/II, 26% Stage III, 32% Stage IV
Small bowel adenocarcinoma

Diagnosis

- Imaging: barium small bowel follow-through +/- enteroclysis, capsule endoscopy, CT and MRI enterography.
- Diagnosis confirmed by biopsy usually during surgical management
- Differential: chronic duodenal ulcer disease, Crohn’s disease, other small bowel tumor

Treatment

- Surgical: Wide local excision with lymphadenectomy
- Chemotherapy for metastatic or unresectable disease
References
