Two overlapping uncovered metallic stents for duodenal obstruction due to primary lymphoma

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Primary non-Hodgkin’s lymphoma (NHL) of the duodenum is an uncommon primary tumor of the gastrointestinal tract which accounts for less than 12% of all NHL [1,2]. Obstruction is a preterminal event. A decision-analytic model comparing open gastrojejunostomy, laparoscopic gastrojejunostomy, and endoscopic stenting for malignant gastroduodenal obstruction showed that self-expandable metal stent (SEMS) placement was the most cost-effective strategy and was associated with the lowest rate of complications and the highest success rate over a 1-month period [3]. This is a rare case of primary duodenal lymphoma with a poor response to chemotherapy, inoperable given the poor nutritional status and treated with SEMSs. A 24-year-old man was referred to our hospital with abdominal pain and upper obstruction signs, consisting of nausea, vomiting, dysphagia and progressive weight loss. Physical examination showed tenderness in the epigastrium without peripheral lymphadenopathy, hepatosplenomegaly, or intra-abdominal mass. Laboratory tests were normal. Upper gastrointestinal endoscopy demonstrated an ulcerated polypoid lesion with a near-complete duodenal obstruction. Histopathology of the lesion was compatible with large B-cell lymphomas and immunohistochemical study was positive for CD20. Abdominal CT scans showed a circumferential thickening of the duodenal wall and revealed several lymph nodes. Chest CT scans showed no evidence of lymph node enlargement in the mediastinum. Bone marrow laboratory showed no tumor infiltration. Our patient received several cycles of systemic Rituximab (Mabthera®), Cyclophosphamide, Doxorubicine, Vincristine, Prednisone. This treatment failed to ameliorate the obstructive symptoms with objective weight loss of 9 kg. Upper endoscopy showed a near-complete obstruction. To alleviate this obstruction surgical intervention was deemed necessary but impossible given the poor nutritional status of our patient. In conscious sedation under both fluoroscopic and endoscopic control, a 0.035-inch biliary guidewire was indwelled over the stenosis (Fig. 1A). Without balloon dilatation, due to the length and anatomy of the stricture, and to a tendency for the stent to move away from the stricture it was essential to insert two overlapping uncovered SEMSs through the scope, 22 mm in diameter and 60mm in length (WallFlex duodenal stent, Boston Scientific) in D2-D3 and D1-D2.
No immediate complications were noted. The patient resumed oral intake immediately, received proton pump inhibitor treatment and was instructed to avoid leafy and uncooked vegetables. A few days after insertion the abdominal X-ray control showed the two overlapping SEMSs in place (Fig. 2).

After follow up of 36 months, no migration, re-obstruction, or occlusion was noted in our patient with two uncovered stents. Our patient was able to resume oral intake with objective weight gain of 10 kg. Endoscopic controls regularly performed showed the two SEMSs in place and functional (Fig. 1B).

Duodenal SEMSs are still underused in patients with malignant gastroduodenal obstruction. In our patient presenting a primary duodenal obstructing lymphoma, the SEMSs placement was effective in alleviating the intestinal obstruction. SEMSs should be recommended in treatment of malignant gastroduodenal obstruction especially in patients with poor performance status.

References


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