Myeloid sarcoma of the duodenum: a rare cause of bowel obstruction and gastrointestinal bleeding

A 78-year-old man with known relapsing acute myeloid leukemia (AML) presented to the emergency department with a 24-hour history of vomiting. On arrival, he had evidence of coffee ground emesis, his heart rate was 115 beats/minute, and his blood pressure was 135/89 mmHg. A computed tomography (CT) scan of the abdomen performed to rule out gastric outlet obstruction revealed an obstructive luminal mass in the fourth part of the duodenum (Fig. 1). On enteroscopy, the mass was found to be friable, measuring 5 cm in diameter and occupying 75% of the duodenal circumference (Fig. 2). The lesion bled on contact and on taking biopsies, but the bleeding was controlled by application of the hemostatic powder TC-325 (Hemospray; Cook Medical, Winston-Salem, North Carolina, USA). Histology showed total replacement of the tissue in the biopsy by medium atypical blast-like cells consistent with myeloid sarcoma (Fig. 3), as per the WHO classification, 2008. After a discussion with the oncologist, the patient opted for palliation without further active treatment.

Myeloid sarcoma is the extramedullary manifestation of AML, causing discrete tumor masses rather than diffuse infiltration. It occurs in the skin, lymph nodes, gastrointestinal tract, testis, or bone, and may occur prior to, concurrent with, or following a diagnosis of AML or another myeloproliferative disorder [1, 2]. Involvement of the duodenum is rare, with only eight cases reported in the literature and with most patients presenting with either abdominal pain or bowel obstruction [3]. Although bleeding arising from myeloid sarcoma has been reported in other parts of the gastrointestinal tract, to our knowledge, this represents the first reported case of a duodenal myeloid sarcoma presenting with upper gastrointestinal bleeding (UGIB). In addition, this report demonstrates the successful application of TC-325, a promising hemostatic powder, in the management of UGIB due to malignancy [4].

Clinicians should keep in mind this rare entity when approaching a patient with bowel obstruction or UGIB, particularly in the presence of a myeloproliferative disorder.
Endoscopy_UCTN_Code_CCL_1AB_2AZ_3AB

Competing interests: None

Yen-I Chen1, Philippe Paci2, René P. Michel3, Talat Bessissow1
1 Division of Gastroenterology and Hepatology, McGill University Health Center, McGill University, Montreal, Quebec, Canada
2 Division of General Surgery, McGill University Health Center, McGill University, Montreal, Quebec, Canada
3 Department of Pathology, McGill University Health Center, McGill University, Montreal, Quebec, Canada

References

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1391502
Endoscopy 2015; 47: E181–E182
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
Talat Bessissow, MDCM, FRCP
Division of Gastroenterology and Hepatology
McGill University Health Center
1650, Cedar Avenue 7th floor
C7-200 Montreal
Quebec H3G 1A4
Canada
Phone: +1-514-692-5937
talat.bessissow@mcgill.ca