A 68-year-old man referred to the Internal Medicine Department of Razi Hospital in Rasht (a city in the north of Iran) with a hypogastric region discomfort, especially in the right lower quadrant for one month.
The pain was a colicky form which had a few episodes each day, each episode lasting for 4–5 minutes.
The pain radiated to the back and was alleviated by resting to one side.
No association between the pain, defecation, and eating were reported.
Furthermore, the patient complained of a 2–3 kg weight loss over the last one month followed by anorexia.
However, no symptoms of nausea, vomiting, fever, or shaking chills were demonstrated.
He was first admitted to another center for a week, then was referred to our hospital for further evaluation.
The patient had undergone a surgery for prostatectomy seven years before his presentation to our center.
Also, he had a history of endoscopy five years earlier due to dyspepsia, which was found to be Helicobacter pylori positive at that time and which was eradicated after a treatment course.
No history of HIV, diabetes, smoking, or alcohol consumption was recorded.
His vital signs were normal at the time of admission.
On physical examination, the abdomen was soft, there was no distention, and bowel sounds were normoactive.
However, tenderness in the right lower quadrant of the abdomen with no rebound state was noted.
The peripheral blood analysis is shown in Table 1.
Stool examination, urine analysis, and evaluation of electrolytes were all normal.
An abdominal CT scan showed a well-demarcated and homogenous solitary mass in the cecum with no distention in the ileum.
The ileum wall was thickened (Figure 1).
A colonoscopy revealed a large mass like lesion in the cecum (Figure 2); during the procedure a biopsy was taken from the cecum.
The lamina propria was infiltrated by a number of PMNCs admixed by some eosinophils (Figure 3).
Immunohistochemical evaluation was positive for vimentin and CD68.
C-Kit (CD117) was negative while CD34, smooth muscle actin (SMA), and ALK were focally positive.
There were no reports of cyclin D1, desmin, or pancytokeratin (Figure 4).When the colonoscopy was performed, the evidences of invasive obstruction lead us to the suspicion of a malignant tumor.
After pathological confirmation of IMT, the patient was referred for surgery in order to remove the mass.
On surgery, approximately 40 mL ascites were found in the abdomen.
A mass was seen in the cecum with ileocolic intussusception.
Afterwards, the patient underwent right hemicolectomy with an end-to-end anastomosis of ileocolic.
No enlarge lymph nodes were observed.
The patient was discharged seven days after surgery and had no complications during follow-up.