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CAVERNOUS HEMANGIOMA (CAVERNOUS), OF ILEUM

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Hemangioma of the small intestine is rare. A case of cavernoma of the ileum was discovered at the Riverside Sanitarium and Hospital at Nashville, Tennessee. This tumor was found during a laparotomy on a female patient who had complained of increasing severity of abdominal pain over a period of two years.

A very few cases of this condition of the small bowel has been reported during the last ten years. McCallum states, "I have seen one or two cases of multiple cavernous hemangioma in the walls of the intestines. Hemorrhage may occur from these, although it had not done so in our cases." Babcock says, "Hemangioma, while uncommon in the intestines, may cause obscure intestinal hemorrhages, when it should be removed by excision or cautery destruction."


REPORT OF CASE

A forty-three-year-old Negro female complained of a griping pain in the midline of the lower abdomen and back of two years' duration. The pain had increased in severity and was worse in the morning and at night. For one year she was nauseated each morning and vomited occasionally. This nausea was associated with epigastric pain. Two times before admittance she noticed her feces were mixed with dark red blood. The patient went to various physicians and received various diagnoses. She was admitted to the Riverside Sanitarium and Hospital at Nashville, Tennessee, on December 4, 1944. Examination revealed tenderness over the lower lumbar spine on beating and mild tenderness in the epigastrium. A great deal of tenderness was present in the midline of the lower abdomen. No rigidity or palpable mass was noted. The routine laboratory tests were normal. The patient had not menstruated for eleven months.

A laparotomy was performed on December 6, 1944, in light of the increasing severity of abdominal pain and lack of a specific symptom complex. Ethyl chloride and ether anesthesia were employed. A midline incision was made and the abdominal contents exposed. The uterus was about the size of an orange. The gallbladder, stomach, spleen, kidneys, liver, and large bowels were normal. The ileum had seven inches of its surface covered with many dilated, dark, and tortuous vessels, many of which were thrombotic. Large hematomas could be palpated within the lumen. The area of the tumor was resected, and the two ends of the gut sutured closed. The intestines were united by a side-to-side anastomosis. The defect in the mesentery was closed. No nodes were palpable at operation. The abdomen was closed after removal of the appendix and instillation of sulfanilamide crystals.

Twelve hours after operation a Levine tube was introduced into the stomach and some fluid removed. Fluid was removed by Wagenstein suction each time the patient had the least discomfort. One thousand cc. of 5 per cent glucose in normal saline and 2,000 cc. of 5 per cent glucose in distilled water were given in three doses daily intravenously for four days. Twenty-five cc. of amino acids were given in each dose. The Levine tube was removed on the fourth day, and water was given to drink. The clips were removed on the fifth day, at which time surgical liquids were given and continued for five days. Mineral oil was
given nightly, beginning on the fourth day. The temperature did not go above 100°F., and the abdomen did not become distended.

The pathological specimen was seen by two pathologists—Dr. J. R. Cuff, of Meharry Medical College; and Dr. C. E. Kendall, of Madison Sanitarium. They examined the specimen grossly and microscopically. They report that the specimen consisted of twelve centimeters of small intestine and a moderate amount of mesenteric fat. The tissue was relatively soft. The lumen was not dilated, and when opened showed polypoid masses that were dark reddish brown and varied from 0.8 to 1.3 cm. Many areas of hyperemia and acute ulceration were noted. These followed the transverse axis of the specimen and corresponded with the areas of fibrin seen on the surface. The wall was slightly thickened. The serosa was pink and showed dilated blood vessels that were filled with blood clots. Beneath the mucosa there were several raised, firm nodules, the cross section of which showed beginning organization by fibrin tissue.

The microscopic appearance (Dr. Cuff) showed the mucosa intact. Groups of vessels in the submucosa showed dilatations simulating those seen in the cavernous type of hemangioma. In one section a circular calcified mass was seen at the base of this dilated group of vessels. In other areas a linear perivascular distribution of lymphocytes was present. Occasional vessels showed complete obliteration of the lumen by fibrous connective tissue which was not concerned with an organizing process. Other vessels showed acute proliferation of the subendothelial connective tissue, while the vessels in the mesenteric fat showed the characteristic picture of the slowly developing type of proliferative arteritis. A portion of lymphonode showed no unusual change. The acute degenerative changes mentioned in the gross description did not appear in the sections, but the polypoid masses were seen to contain much blood and showed many trabeculations. The diagnosis of Dr. Cuff was cavernous hemangioma and proliferative arteritis. Dr. Kendall states that the mucosal layer showed only fairly normal appearing crypts separated by fibrous tissue that contained small round cell infiltration and a moderately diffuse infiltration with eosinophiles and a few polymorphoneclears. The submucosal and muscular layers contained many blood vessels whose walls appeared to be somewhat thickened by fibrous tissue, and the lumen of the blood vessels was distended with hemorrhage. There was no evidence of malignancy or specific lesion. The diagnosis of Dr. Kendall was hemangioma of the ileum.

In June, 1946, when this patient was again seen she was entirely relieved of symptoms and had gained weight.

CONCLUSION

1. An unusual case of cavernous hemangioma of the ileum is described.

2. The symptom complex of griping lower abdominal pain in the midline and back, nausea, occasional blood in the stools, and midline abdominal tenderness should bring to mind the possibility of intestinal hemangioma.

BIBLIOGRAPHY


