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Case Report

*Corresponding author

Fabio Pagni, MD

Department of Surgery and Interdisciplinary Medicine Pathology
University Milan Bicocca
San Gerardo Hospital
20900, Monza, Italy

E-mail: Fabio.pagni@unimib.it

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Amyloidotic Tumor of the Duodenum

Marta Jaconi[1], Roberto Frego[2] and Fabio Pagni[1*]

[1]Department of Pathology, University Milan Bicocca, San Gerardo Hospital, Monza, Italy

[2]Endoscopy Unit, San Gerardo Hospital, Monza, Italy

OVERVIEW OF THE CASE

During a 77-year-old woman's esophageal gastroduodenoscopy (EGDS), this duodenal polypoid lesion was discovered (Figure 1A). A few years prior, our patient had been diagnosed with multiple myeloma; despite receiving several lines of treatment, the disease was still progressing, resulting in multiple vertebral localizations and renal failure. Over the course of two weeks, she began to complain of asthenia and experienced multiple episodes of melena; the ER evaluation revealed severe anemia (Hb 5.9 g/dl) and Deep Venous Thrombosis (DVT). She received three blood transfusions to stabilize her, and then an EGDS was performed to identify the bleeding source. Because the polypoid lesion prompted fears of myeloma location, duodenal primary tumor, or infectious illness, a biopsy was performed. Instead, histology ruled out the presence of a malignant tumor but did find large deposits of an amorphous eosinophilic material on the mucosa and submucosa (Figure 1B), which stained with Congo red (Figures 1C and 1D) and displayed apple-green birefringence. Tumoral intestinal AL amyloidosis was diagnosed.

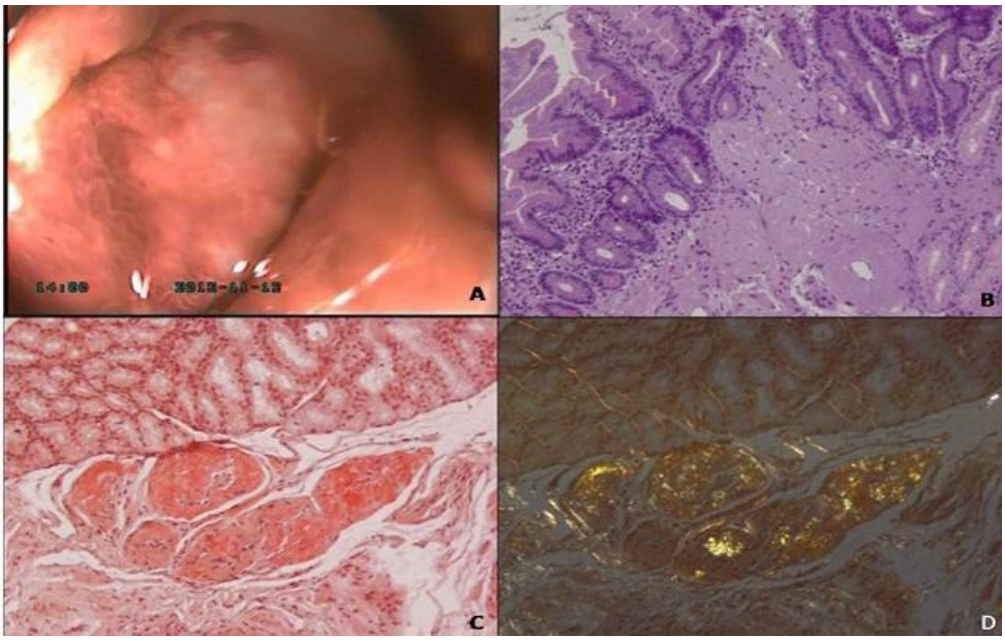

Figure 1: A: Endoscopic appearance of this duodenal polypoid vegetant lesion; B: Haematoxylin & Eosin stain revealed absence of malignancy; the pseudotumoral appearance was due to the presence of abundant amorphous material consistent with amyloid; C-D: Congo Red histochemistry confirmed the morphological suspicion.

DISCUSSION

The most prevalent type of amyloidosis and the only one associated with multiple myeloma is primary amyloidosis. Abnormal antibody fragments (light chains) are the reason.

Amyloid is the sole kind that develops in multiple myeloma and can form deposits in loidosis. Abnormal antibody fragments (light chains) are the reason. Several organs, including the kidneys, liver, myocardial tissue, skin, and peripheral nervous system, can develop deposits of amyloid; however, none of these organs were affected in our case. About 8% of individuals will experience gastrointestinal (GI) involvement, which is extremely uncommon and frequently subclinical. The mass-forming pattern is even less common because the deposits are often straight and manifest as larger folds and mucosal thickening.2. Weight loss, diarrhea, malabsorption, pseudo-obstacle, perforation, and gastrointestinal bleeding are the most typical signs of GI amyloidosis, and they are all linked to vascular friability.3, 4 GI amyloidosis can mimic a variety of benign and malignant conditions during endoscopy, such as flat, ulcerative, or vegetant tumors. Particularly in these isolated presentations, only the histological examination enables the development of an accurate diagnosis and an appropriate course of treatment.5. We present this case as an illustration of a rare but unusual diagnostic hazard that has been called "amyloidoma" in the literature. Similar to other non-neoplastic lesions such GI xanthomas, inflammatory and lymphoid polyps, and heterotopic gastric or pancreatic tissues, amyloidotic tumors can deceive both clinical examination and imaging.6. In order to determine their true nature, all of these instances have also required biopsies. However, due to the danger of catastrophic GI hemorrhage, myeloablative chemotherapy is not provided to patients with GI amyloidosis and signs of active GI bleeding or ulceration.7. Patients who do not respond to chemotherapeutic regimens are typically treated with melphalan and dexamethasone or new medicines in clinical trials.7

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