

Letters to the Editor

Schwannoma in descending colon: Presentation of a neoplasm in a rare location

Key words: Schwannoma. Colon. Diagnosis. Gastrointestinal neoplasms.

Dear Editor,

Schwannomas of the gastrointestinal tract are uncommon tumours originating in the cells of Schwann of the peripheral nerves and accounting for 2-6 % of all mesenchymal tumours. They usually appear in the stomach or small intestine and less frequently in the colon.

Case report

We present a 67-year-old male in whom a screening colonoscopy revealed an ulcerated polypoid lesion 35 cm from the anal margin. The biopsy was unspecific. CT and virtual colonography showed a 4.5 x 3.6 x 3.7 cm polypoid mass in the left colon with regional adenopathies but no distant metastases. The patient was admitted to the emergency department for rectorrhage and abdominal pain. Ultrasonography showed a colico-colic invagination caused by the polypoid mass. The patient underwent a midline laparotomy, which revealed an invagination in the descending colon, but no infiltration or distant dissemination. A segmental colectomy was performed with a mechanical side-to-side anastomosis. The patient evolved favourably. The anatomicopathological study informed of a well-circumscribed yellow-

ish-white submucosal tumour made up of spindle cells forming palisades, an intratumoural lymphoid infiltrate with peripheral nodules, and low mitotic activity. Immunohistochemical tests were positive for S-100 and CD68 but there was no reactivity for CD117, CD34, actin and CD10 (Fig. 1). The definitive diagnosis was schwannoma of the colon. No recurrence has been observed in 3 years of follow-up.

Discussion

Schwannomas are common in subjects with von Recklinghausen's disease (1,2). The colon is a rare location, and when they appear they are most often found in the caecum, followed by the sigmoid colon, transverse colon, descending colon (as in our case) and finally the rectum. They are benign neoplasms that rarely degenerate (3). They usually present as a polyp which may ulcerate the mucosa (4,5) and lead to unspecific symptoms such as abdominal pain with rectal bleeding, defecation disorders, colonic obstruction or invagination, as in our patient (6,7). Imaging tests are unspecific. CT shows a well-defined homogeneous

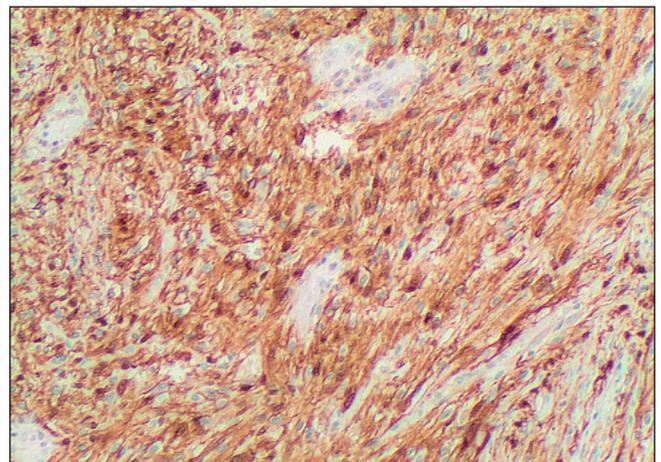


Fig. 1. Positive for S-100.

mural mass and differentiates them from GISTs (gastrointestinal stromal tumours), which are heterogeneous masses (8). On most occasions diagnosis is not established from the biopsy, but from the surgical specimen (9).

Macroscopically they are well-circumscribed yellowish-white lesions. Microscopically they are arranged in a pattern of intertwined bundles surrounded by an infiltrate of lymphoid cells with germinal centres and small foci of cellular atypia with low mitotic activity (10). An immunohistochemical study is very useful for a differential diagnosis with other lesions such as GISTs, GANTs (a variant of GISTs derived from the autonomic nerves), leiomyomas or leiomyosarcomas, which can show a more aggressive behaviour (11). Schwannomas usually express a positive reaction for S-100, vimentin and GFAP, but no reactivity for the transmembrane receptor tyrosine kinase known as c-KIT or CD117, the precursor cell antigen of the haematopoietic system CD34, actin or cytokeratins, which do appear more typically in GISTs, GANTs or muscle tumours (12,13). After diagnosis, the options are to perform a polypectomy or segmental colectomy with free margins, due to the low risk of malignancy (14,15). Because of their benignity these patients have a good prognosis. Recurrence or the presence of metastases is very rare.

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