Vanek’s tumour mimicking an acute appendicitis

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ABSTRACT
INTRODUCTION: Vanek’s tumour or Inflammatory Fibroid Polyp (IFP) are rare, benign localised lesions originating from the sub-mucosa of the gastrointestinal tract (GI) tract. They have been widely reported as occurring within the stomach, Duodenum, Jejunum and ileum, more rarely (<1%) in the caecum or appendix.

PRESENTATION OF CASE: We present a case of a 28-year-old lady who presented with a 2-day history of right iliac fossa pain, nausea and low-grade fever. Subsequent, ultrasonography (US) of the abdomen demonstrated an inflamed tubular structure originating from caecum with fluid in the pelvis mimicking an acute appendicitis. Next to normal appendix an inflammatory polypoid mass was identified and on histological examination confirmed to be an IFP (Vanek’s tumour).

DISCUSSION: Right Iliac Fossa (RIF) pain with suspected appendicitis is one of the most common presentations in any acute surgical unit. In young women of childbearing age, the differential diagnosis can be varied and vast. The surgical management of IFP (Vanek’s tumour) in such cases ranges from limited resection and caecectomy to limited right hemicolectomy.

CONCLUSION: To date, the exact histiogenesis of these tumours remains unclear and requires a high level of intra-operative suspicion. According to our search such presentation is not reported.

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1. Introduction

Inflammatory Fibroid Polyp (IFP) or Vanek’s tumour was first described as ‘Eosinophilic inflammatory infiltrate’ by Vanek in 1949.1 Since then IFP (Vanek’s tumour) has been well documented in literature as occurring throughout the Gastrointestinal (GI) tract, the gastric antrum followed by the ileum being the most common sites of occurrence. Vanek tumours are often found incidentally on endoscopy for other (unrelated) pathologies. When symptomatic, depending on the site and extent of the tumour, they can cause abdominal pain, weight loss, vomiting, early satiety and upper GI haemorrhage.2,3

2. Presentation of case

A previously well 28-year-old female presented to the emergency department with a 2-day history of right iliac fossa pain worse on movement, pyrexia, nausea without vomiting. There was no history of weight loss, change in bowel habit, urinary or gynaecological pathology. On examination, the abdomen appeared normal without any scars suggesting no previous abdominal surgery. The abdomen was soft, the right iliac fossa was tender with no sign of peritonitis. Urine examination was clear, a full blood count was unremarkable, liver function tests demonstrated an isolated mildly elevated Alanine transaminase (ALT) at 54 units per litre of serum and C-Reactive Protein (CRP) was 8.

Plain film radiographs were unremarkable. An inpatient abdominal Ultrasound scan demonstrated a thickened, inflamed tubular structure originating from the caecum with fluid in pelvis, suggestive of an acute appendicitis (Fig. 1(1) and (2)).

The patient was taken to theatre for open appendicectomy. Entry into the abdomen was obtained using a Lanz incision and the appendix was identified. The appendix itself appeared macroscopically normal, however next to the appendix an unusual oedematous lesion was noted on the caecum (Fig. 2).

An appendicectomy and partial limited caecectomy was performed. The patient made an uneventful recovery and was discharged 2 days later.

Histological examination revealed an appendix measuring 40 mm × 6 mm showing fibrous obliteration of its lumen but no active inflammation within its walls. The caecal mass measured 26 mm × 20 mm with a central polypoid inflammatory mass in which there was extensive sub mucosal oedema, vascular congestion, focal haemorrhage and abundance of fibrin deposition with no evidence of neoplasia.

3. Discussion

Inflammatory fibroid polyps or Vanek tumour are rare conditions that can occur throughout the entire GI tract. Most commonly, these benign lesions occur in the gastric antrum and the small bowel. Even more rarely they can occur in the caecum and the
appendix. Tumours causing small bowel obstruction and intussusception have also been reported requiring emergent surgery.4,5

The overall incidence of IFP (Vanek’s tumour) is thought to be equal in both men and women. As yet no single agent or factor has proven to be causative. Reports of possible upper GI IFP and helicobacter have been implicated but as yet no definitive link has been found. The occurrence of Vanek tumours in the caecum is exceptionally rare, accounting for less than 1% of all IFP.6

Microscopically, the lesions appear as mesenchymal proliferation with extensive connective tissue fibres and vascularity with the presence of large numbers of inflammatory cells predominantly Eosinophils and lymphocytes.7 The aetiology of the condition remains unclear although poor control over the normal inflammatory repair mechanisms has been suggested as a possible explanation.8 Other reports have suggested that the origins of these tumours are from localised vascular inflammation by proliferation of CD34 cells.9

Owing to their rarity and their often asymptomatic nature, their diagnosis is often only made on interventional investigations (such as endoscopy) and histopathology. When symptomatic and depending on the site of lesions they can mimic a whole variety of conditions affecting the upper GI tract including peptic ulcer disease and appendicitis.

4. Conclusion

In this case, a seemingly straightforward case of appendicitis in a young female turned out to be a surprising discovery of IFP (Vanek’s tumour) and according to our search this type of presentation is not reported in the literature. Cases of symptomatic IFP (Vanek’s tumour) can be difficult to diagnose, therefore a high level of clinical and intra-operative suspicion is required.

Conflict of Interest Statement

None.

Funding

None.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Contributors

Mr. Ali Kordzadeh contributed in writing of case report, its final review, collection of images and submission. Mr. Alan Askari contribution with regards to review of literature. Ms. Josie Todd contributed as consultant in-charge of patient and its surgical management.

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