Abstract:
A 55-year-old Indian male presented with complaints of painless progressive anterior abdominal wall mass for two years. Incisional biopsy revealed features of Desmoid tumour. Surgical excision of tumour mass of size 20x15 cm was done and reconstructed with Prolene mesh and right tensor fascia lata myocutaneous flap followed by flap advancement. Resected specimen weighed 1.8 kg and margins were negative for tumour cells. No post operative adjuvant was given. Desmoid tumour is a rare benign tumour caused by proliferation of fibroblastic cells and it shows aggressive infiltrative growth. Surgical resection is treatment of choice in resectable cases with very high recurrence rate.

Keyword: Large Desmoid tumour, abdominal wall

A 55-year-old Indian male presented with painless progressive abdominal mass for two years. There was no history of trauma, previous surgery and any other significant history. Physical examination revealed firm non tender mass of size 20x15 cm in the anterior abdominal wall extending from the umbilical region, epigastria, right lumbar region and involving the rectus abdominis muscle. Skin was adherent to the mass. (Fig 1). Incisional biopsy proved to be inconclusive and the biopsy was repeated. Biopsy revealed nodular proliferation of spindle shaped fibroblasts arranged in bundles with invasion into the fatty tissue which suggests features of Desmoid tumour. Computed tomography report revealed the hypo dense lesion located within the rectus abdominis muscle and subcutaneous plane measuring 15 x 14 cm, and is sharply demarcated. Colonoscopy examination was found to be normal. The tumour was planned for surgical resection. Wide local excision of tumour mass of size 20x15 cm with marginal clearance of 2 cm was performed. Excision of involved right rectus abdominis muscle along with its fascial sheaths was done. Defect was reconstructed with prolene mesh.
and right tensor fascia lata myo-cutaneous flap followed by flap advancement.

(Fig2) Resected specimen weighed 1.8 kg and margins were negative of tumour cells microscopically. There was no adjuvant chemotherapy or radiotherapy given. The patient has been followed up for a period of two years both clinically and radiologically and recurrence has not been found in any part of the body, and most common in abdomen, chest. Increase incidence of desmoids found among female gender, during pregnancy and after trauma and surgery. Abdominal desmoids have association with Gardner’s syndrome and FAP syndrome. Although desmoid tumour shows benign microscopic features, the lesion is locally aggressive with infiltrative growth into surrounding structures. Anterior abdominal wall desmoid tumours are 6-10 cm in diameter. In this case the tumour measured 20x15 cm which is an unusual large presentation. A high recurrence rate after surgery of approximately 25-85% is well documented in studies because of the infiltrative nature of the lesion with resultant incomplete resection. Metastasis is uncommon. Radiotherapy and chemotherapy have limited role. Follow up for recurrence should be done.

REFERENCES


