ocecal resection that included the devitalized ileal segment and ileocolic anastomosis were performed because the mass was possibly malignant. Immunohistopathological examination revealed a low-grade gastrointestinal stromal tumor (GIST), and histological examination indicated that the tumor consisted of spindle cells. The tumor cells stained positively for CD117 and CD34, while no staining with Ki67 was observed. After follow-up for 18 months, she showed no signs of either local regression or distant metastases.

About 75–90% of intussusceptions in adults are secondary to an underlying pathology, with approximately 65% due to benign or malignant neoplasms. Nonneoplastic processes constitute 15–25% of cases, while idiopathic intussusceptions account for about 10% (1,2,4). Most intussusceptions in the small bowel are secondary to benign neoplasms, such as lipoma, leiomyoma, hemangioma, neurofibroma, and inflammatory fibroid polyps. Malignant lesions causing intussusception in the small bowel account for about 15% of cases and are most often metastatic, with melanoma by far the most common metastasis to cause intussusception. GIST and adenocarcinoma rarely cause ileal intussusceptions (5).

GISTs are the most common malignant mesenchymal tumors of the gastrointestinal tract. Intussusception is a very uncommon presentation of these lesions because of their tendency to grow in an extraluminal fashion. The standard treatment for primary GIST is complete surgical resection, with the aim of obtaining negative microscopic margins over the organ of origin (5).

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Intramural small bowel hematoma secondary to use of oral anticoagulant therapy

Oral antikoagülan kullanımına bağlı gelişen ince barsak intramural hematomu

To the Editor,

Intramural hematoma of the small bowel is an infrequent complication of the use of oral anticoagulants, and it is easy to treat. Intramural hematomas of the small bowel usually present with na-

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usea, vomiting, crampy abdominal pain, and often some degree of gastrointestinal bleeding. Diagnosis can only be made with radiological tests and when these symptoms are associated with a history of oral anticoagulant use. It was first reported by McLouchlan in 1838, and the first radiological description regarding jejunal hematoma was given by Liverud more than 100 years later (1). The finding of a long segment of bowel wall thickening in the jejunum in an anticoagulated patient strongly suggests the diagnosis. Spontaneous intramural small bowel hematoma has become increasingly recognized as a complication of anticoagulant therapy, hemophilia, idiopathic thrombocytopenic purpura, leukemia, lymphoma, myeloma, chemotherapy, and vasculitis (2). We present a case with gastrointestinal system obstruction by small bowel hematoma due to use of an oral anticoagulant therapy.

A 71-year-old male patient was admitted to our emergency department with sudden onset of abdominal pain, nausea and vomiting for three days. He had a 10-year history of epilepsy, hypertension and stroke under medical control. He had a medical history of stroke, for which he was anticoagulated with 5 mg/day warfarin. There was no history of trauma. Vital signs were within the normal ranges. Physical examination in the emergency unit revealed diffuse abdominal tenderness with mild rebound pain. Coagulation tests were abnormal with a prolonged prothrombin time (PT) of 126.2 seconds (sec) (normal range: 10.8–14.5 sec), an international normalized ratio (INR) of 9.94, and a prolonged activated partial thromboplastin time (aPTT) of >120 sec (normal range: 19.1–29.0 sec). Other blood tests revealed normal hemoglobin and marginally increased white blood cell count (WBC, 10.3) and C-reactive protein (CRP, 80)

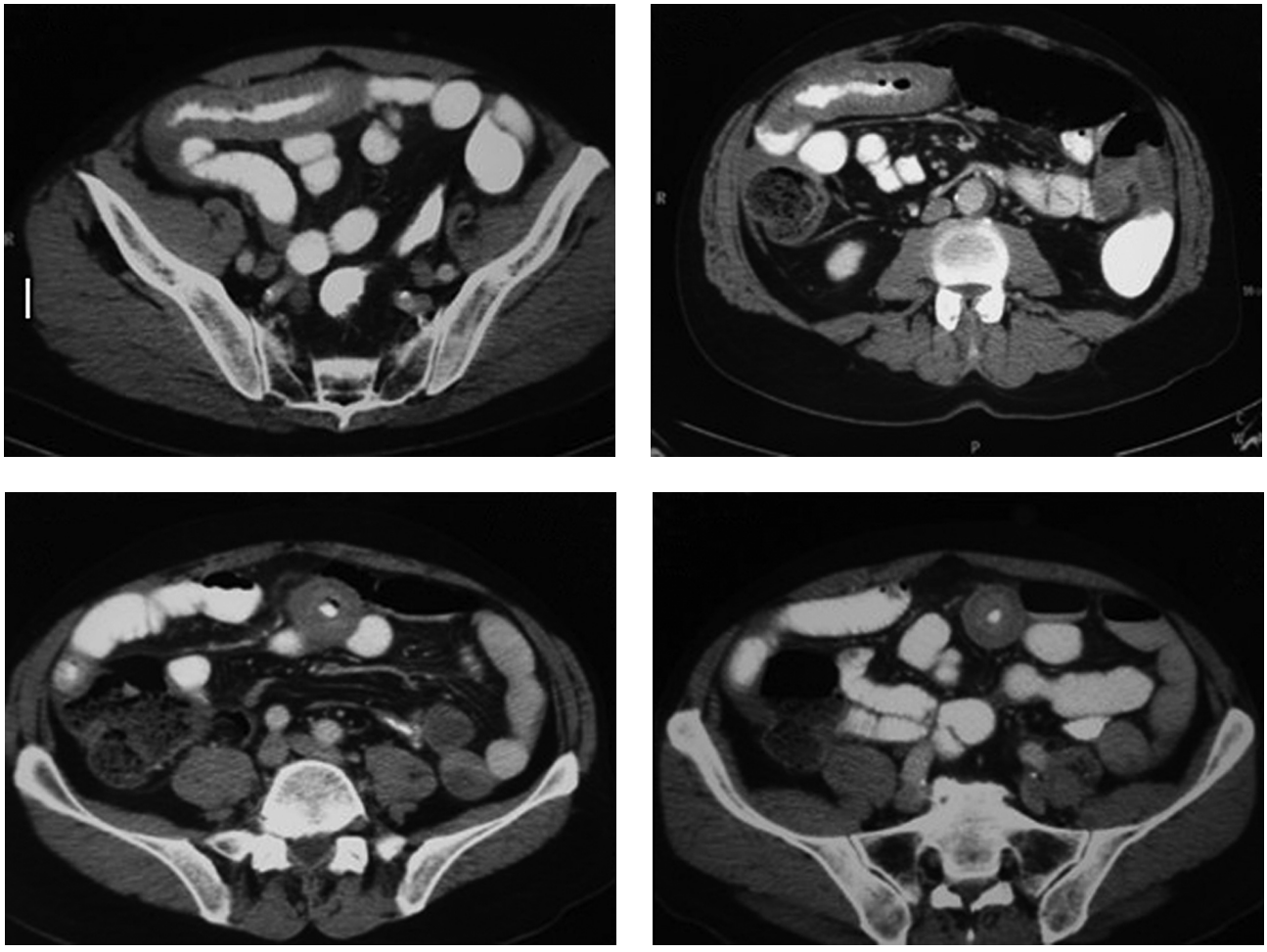

Figure 1. Abdominal CT showing circumferential small bowel wall thickening with intramural hyperdensity and luminal narrowing in the right lower abdomen on first admission.

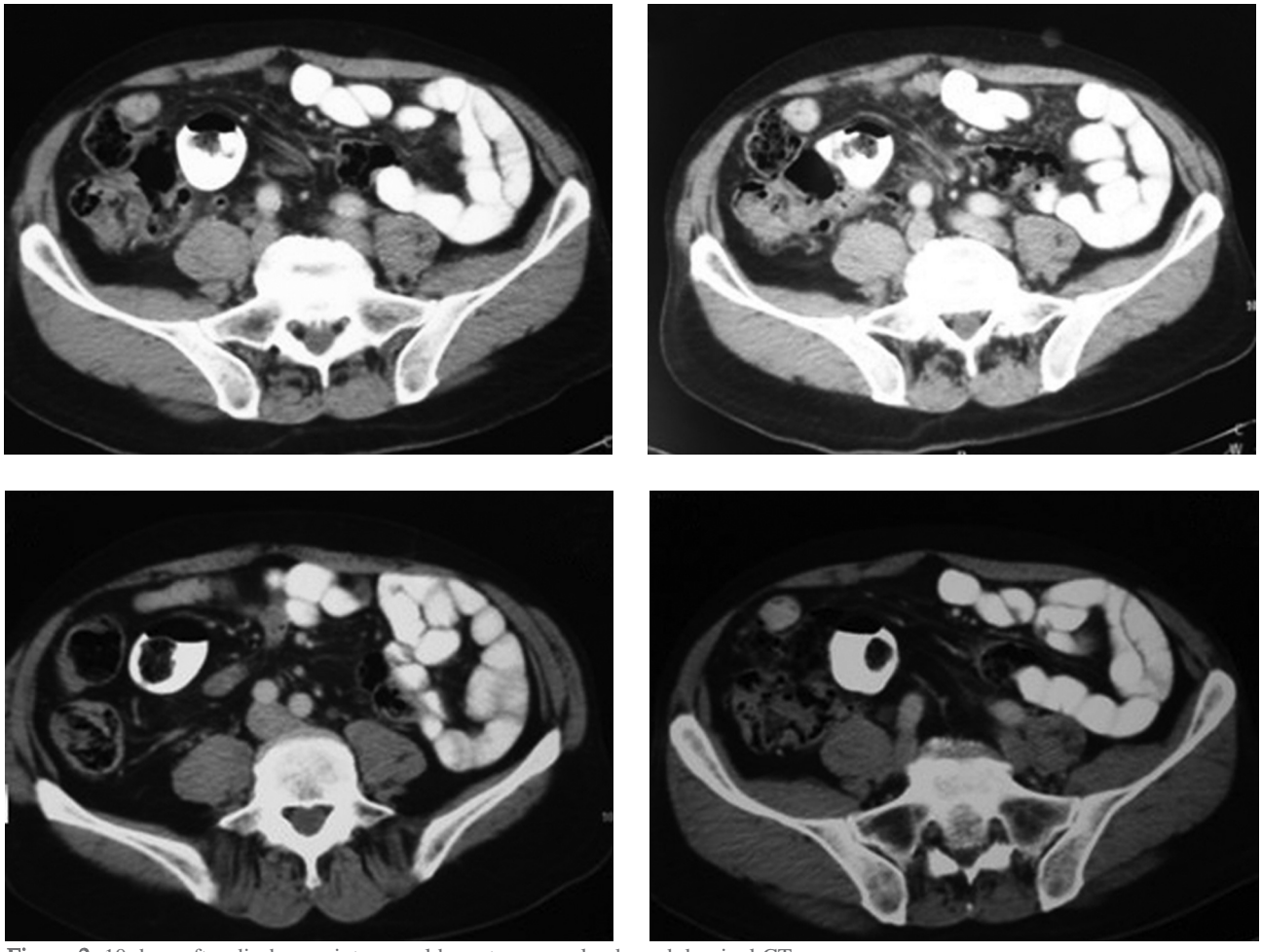

Figure 2. 10 days after discharge intramural hematoma resolved on abdominal CT.

level. In X-ray abdominal radiography, gas-fluid levels were detected. Emergent computed tomography (CT) of the abdomen showed circumferential small bowel wall thickening with intramural hyperdensity and luminal narrowing in the right lower abdomen (Figure 1). During the first day of hospitalization, intravenous fluids and nasogastric suction were done. Warfarin was discontinued, and 1 mg vitamin K and two units of fresh frozen plasma were administered under PT, aPTT and INR guidance. After this treatment, the values of the coagulation test were seen to decrease (PT: 33.7 sec, aPTT: 65.5 sec, INR: 2.78), and the abdominal pain gradually subsided. He was discharged two days later in stable condition.

For thrombosis prophylactic, low molecular weight heparin (0.6 cc/day) was started. The patient was doing well at follow-up 10 days after discharge. All biochemical tests (WBC: 6.8, CRP: 7.6, PT: 9.9 sec, aPTT: 23.6 sec, INR: 0.85) were within normal range. Abdominal CT demonstrated that most of the intramural hematoma had resolved (Figure 2).

Oral anticoagulants are widely used in many indications, such as pulmonary embolism, deep vein thrombosis, prosthetic heart valves, and persistent atrial fibrillation (3,4). Before the advent of anticoagulant therapy, most cases of intramural hematoma were related to trauma (5). The most serious complication associated with the use of warfarin is bleeding due to excess anticoagulation, occurring in approximately 7.6 per 100 patient-years (4). Bleeding is usually subcutaneous or intramuscular. Spontaneous intestinal intramural hematoma is an uncommon complication of anticoagulation. Incidence of spontaneous intramural hematoma is reported to be 1 per 2500 anticoagulated patients (6). Lesions in the large intestine are now reported less frequently than in the past (7). Most intramural hematomas are single and

most commonly involve the jejunum, followed by the ileum and the duodenum (6). The clinical manifestations of warfarin toxicity vary from vague abdominal pain, nausea, vomiting, and acute abdomen to intestinal obstruction and gastrointestinal bleeding (2,8). The mainstay of management is medical treatment and discontinuing the anticoagulant drugs, bowel rest, correction of PT with intravenous vitamin K and fresh frozen plasma, and correction of anemia, if present (8,9). Historically, most cases of spontaneous intestinal hematoma have been diagnosed at laparotomy (10). If correctly diagnosed pre-operatively, conservative management with restoration of coagulation parameters leads to a satisfactory recovery in most cases. Surgical intervention is indicated only if there is significant intramural hemorrhage, bowel perforation, ischemia, or peritonitis (2,9).

In conclusion, spontaneous intestinal intramural hematoma is an uncommon complication of anticoagulation. The most common presentation is acute abdomen. A high index of suspicion is required to manage these patients appropriately and avoid unnecessary surgical interventions.

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A rare cause of lymphadenopathy near the terminal ileum: immunoproliferative small intestinal disease

Terminal ileum komşuluğunda görülen lenfadenopatinin nadir bir nedeni: İmmunoproliferatif ince barsak hastalığı

To the Editor,

Immunoproliferative small intestinal disease (IPSID) is a subtype of mucosa-associated lymphoid tissue (MALT) lymphoma. *Campylobacter jejuni* is suspected in the etiology. The most frequently af-

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