

visible on the serosal surface, one of which was almost completely obstructing the lumen. There were other ileal lesions that were intramural, firm and mobile and scattered along the small bowel segment. In addition, there was a 4.5-cm mass in the mesentery of the terminal ileal segment that contained the previously mentioned lesions. The segment of ileum containing the lesions and the mesenteric mass were successfully resected. The numerous lesions were reported as neuroendocrine (carcinoid) carcinoma with vascular, lymphatic and perineural invasion. Metastatic disease was identified in 6 of 13 regional lymph nodes retrieved.

Discussion

Among carcinoids, 70%–80% are asymptomatic and found incidentally at the time of operation for symptoms of bowel obstruction or during exploration of the small bowel in search of a primary neoplasm after distant metastases have been found.² Multicentricity has been reported as low as 2%–4%³ for rectal carcinoids and as high as 40% for small bowel carcinoids.⁴ The clinical significance of the multiplicity of small bowel carcinoids and their association with other neoplasms are not fully understood.

Yantiss and colleagues⁵ compared the clinical and pathological features and prognosis of 50 patients with solitary

carcinoids and 18 patients with multiple carcinoids of the ileum. At the time of diagnosis, patients with multiple carcinoids were significantly younger than patients with solitary lesions, there was a high association between multiple carcinoids and the carcinoid syndrome, and there was an association between multiplicity and venous invasion, but this relation was not statistically significant.

Another unusual observation was the frequent coexistence of a second primary malignant neoplasm of a different histologic type.⁶ Usually, this is a synchronous adenocarcinoma (most commonly in the large intestine), and it can occur in 10%–20% of patients with carcinoids. In Morgan and colleagues⁴ review of 135 patients with gastrointestinal carcinoids, associated malignant neoplasms occurred in 26% of patients.

With respect to therapy in both cases, the extent of resection necessary to encompass the disease process, along with its regional metastases, was of concern, especially in case 2, because of the proximity of a large metastatic deposit to the superior mesenteric artery. Nevertheless, the extensive resection was performed to rid the patients of all their visible disease. It is well recognized that operative resection is the mainstay of treatment of intestinal carcinoids.

Competing interests: None declared.

Contributors: Dr. Gordon designed the study. Drs. Sembawa, Lamoureux, Gologan and Gotlieb acquired the data, which Drs. Lamoureux, Gologan and Gordon analyzed. Drs. Sembawa, Lamoureux, Gologan and Gordon wrote the article, which Drs. Lamoureux, Gologan, Gotlieb and Gordon reviewed. All authors gave final approval for publication.

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Correction

The list of online case notes published in the April 2008 issue contained an error.¹ For the case note “Role of the endo-GIA stapler in transanal excision of rectal tumours,” the first author’s name was spelled incorrectly. The correct spelling is G. Montalto. *CJS* apologizes for this error and any inconvenience it may have caused.

Reference

1. Montalto G, Polinari U, Ausania F, et al. Role of the endo-GIA stapler in transanal excision of rectal tumours. *Can J Surg* 2008;51(2):155.