



Non-Traumatic Complete Jejunal Transection Presenting as a Pseudocapsule, Not in Acute Abdomen:

A Case Report on Intestinal T-cell Lymphoma

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INTRODUCTION

The small intestine comprises over 90% of the GI mucosal surface but accounts for only 1.1–2.4% of GI malignancies. Small bowel lymphomas represent 15–20% of these tumors, with only 10–15% of T-cell origin—an aggressive subtype frequently complicated by perforation (up to 74%), typically presenting as acute abdomen.

We report a rare case of a 47-year-old female with intestinal T-cell lymphoma presenting as a concealed complete jejunal transection within a massive pseudocapsule, masking a silent intestinal catastrophe and defying classical surgical expectations.

CASE PRESENTATION

The patient presented with one month of progressive left upper quadrant pain and abdominal distention, later complicated by nausea, vomiting, and melena, with labs showing anemia and leukocytosis, prompted hospital admission.

On examination, the patient was febrile, tachycardic, and hypotensive with a markedly distended abdomen but no peritoneal signs; stabilized after resuscitation and started on antibiotics with NG decompression.

Other laboratory findings revealed electrolyte abnormalities, and hypoalbuminemia. CT showed massive proximal jejunal dilatation with rim-enhancing pseudocapsule and significant mass effect, without pneumoperitoneum.

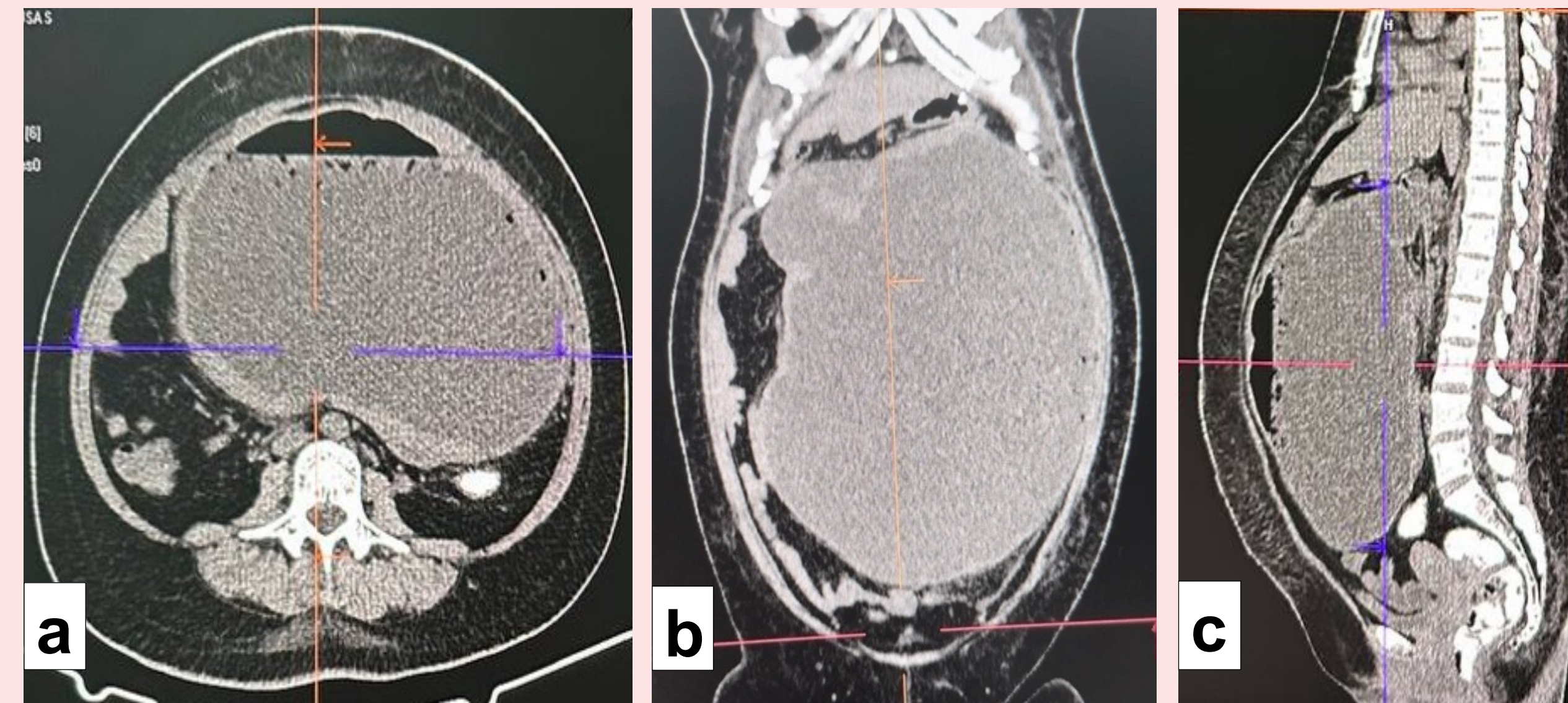


Figure 1 CT Scan of the Whole abdomen with IV contrast revealing a proximal jejunal dilatation which is homogenous with peripheral rim enhancement suggestive of a pseudocapsule. There was minimal ascites but no pneumoperitoneum. (a) Axial view (b) Coronal view: the red arrow indicates a connection between the proximal jejunum and the pseudocapsule. Other abdominal structures were also seen being pushed towards the periphery by the very large pseudocapsule (c) sagittal view

THE SURGERY

Exploratory laparotomy revealed a sealed high-grade jejunal perforation within a large pseudocapsule containing 3.5 L of bilious debris, with complete proximal jejunal transection 5cm from LOT. Segmental jejunal resection with primary anastomosis, lavage and drainage was performed, and the patient was discharged on postoperative day 12.

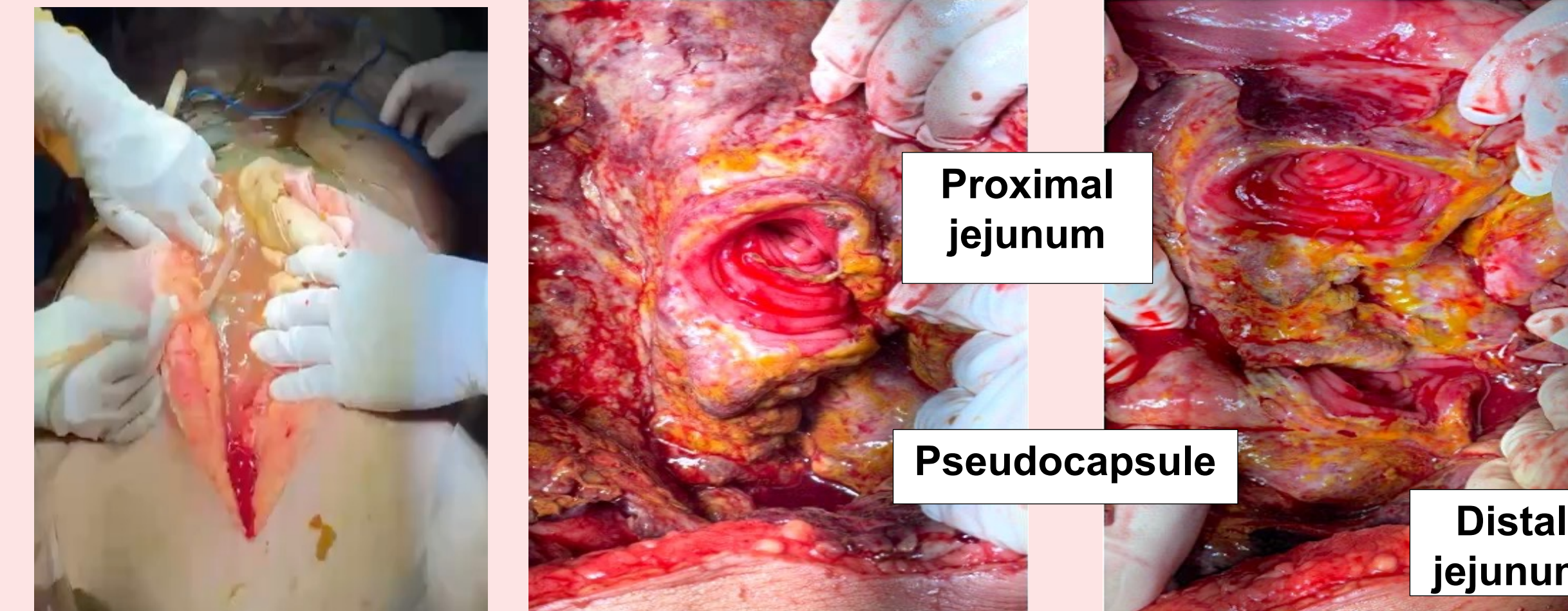


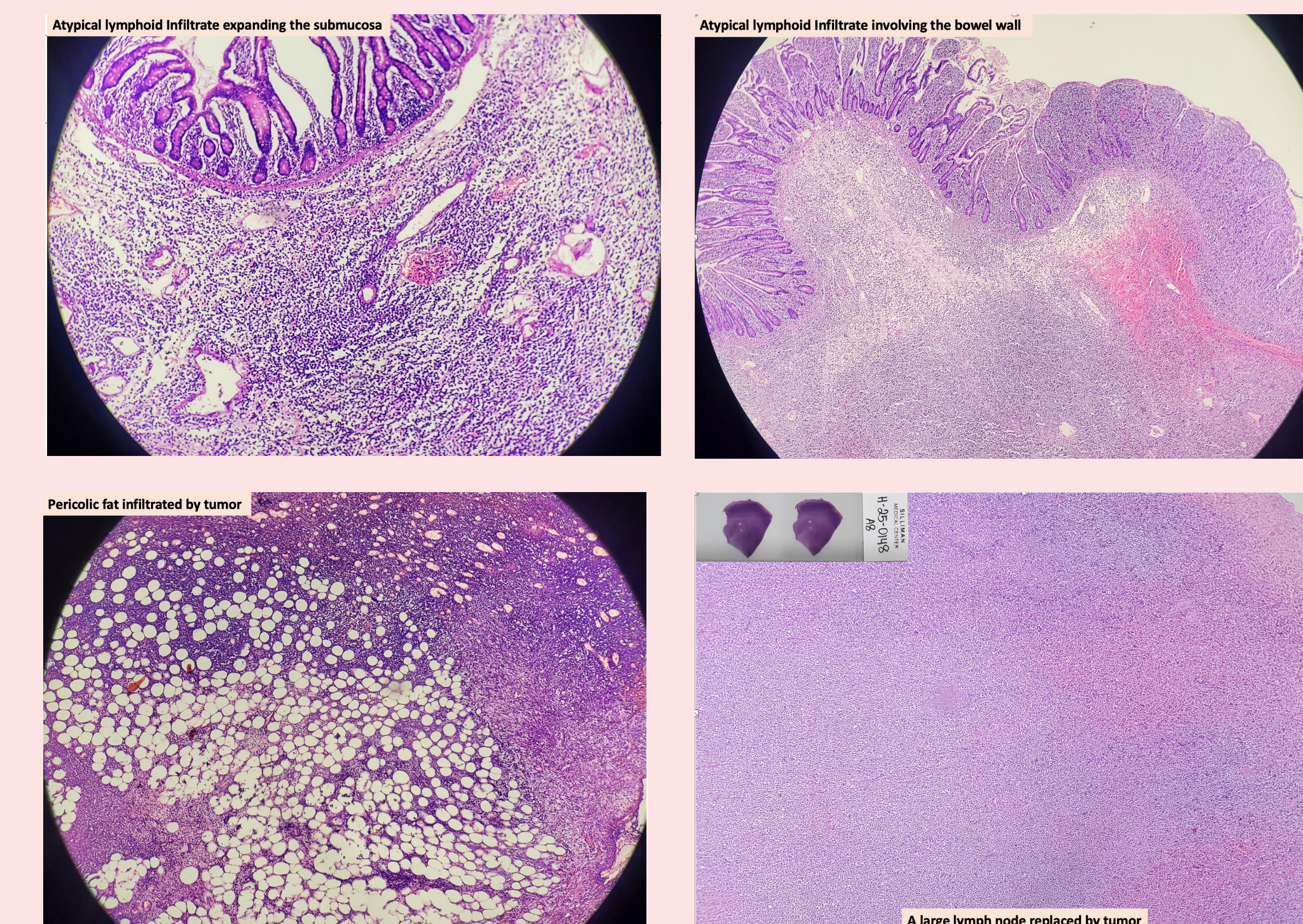
Fig 2 Ruptured pseudocapsule with gushing out of bile and food particles

Fig 3 Transected jejunum : proximal end surrounded by a pseudocapsule

Fig 4 Transected jejunum: proximal and distal ends surrounded by a pseudocapsule

HISTOLOGY

Histopathology confirmed large cell T-cell lymphoma with diffuse full-thickness bowel involvement, pseudocapsule formation, positive resection margins, and lymph node metastasis. Immunohistochemistry was CD3 positive.



FOLLOW - UP

On postoperative day 23, the patient was readmitted with sepsis likely secondary to an anastomotic leak. Despite antibiotics and resuscitation, her condition deteriorated, leading to multiorgan failure and death on postoperative day 28.

DISCUSSION

Small bowel neoplasms are rare, and only 10–15% of intestinal lymphomas arise from T-cells, an aggressive subtype prone to transmural necrosis and perforation. Perforation typically presents as an acute abdomen requiring emergent surgery.

In this case, progressive tumor infiltration resulted in complete proximal jejunal transection that was unexpectedly contained within a large omental pseudocapsule. While omental encapsulation prevented generalized peritonitis, it masked the severity of the perforation and delayed recognition, deviating from the classical presentation.

Histopathology confirmed large cell T-cell lymphoma (CD3 positive) with extensive transmural invasion and margin involvement, predisposing to postoperative anastomotic failure. This case highlights the aggressive biology, diagnostic challenge, and poor prognosis associated with intestinal T-cell lymphoma.