

ATYPICAL ONSET OF GASTRIC NEOPLASM THROUGH PERFORATION

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Keywords: gastric cancer, onset, diagnostic errors

Abstract: The symptoms of gastric cancer are nonspecific and that is why most patients present themselves to the physician in advanced stages. Symptomatology in gastric cancer is similar to gastro-duodenal ulcer, and empirically most often leads to late diagnosis of gastric cancer. The authors present the case of a 74-year-old patient who was laparoscopically cholecystectomized 7 months ago, and a 4-month follow-up was performed in a classical urban hospital for gastric perforation with generalized peritonitis. Both interventions have omitted the patient's gaseous diagnosis - a small bending gas cancer. Subsequently, SCJU Sibiu was diagnosed with gastric cancer, cT3M1N0 and surgically intervened subtotal gastrectomy with restoration of the alimentary circuit by gastro-jejunal anastomosis on the anus in Y a to Roux. Favorable postoperative progression, patient discharged 5 days postoperatively. In our case, besides the empirical therapy for a suspicion of gastro-duodenal ulcer, we also encountered 2 intraoperative diagnostic errors, which led to the detection of gastric cancer in an advanced phase.

INTRODUCTION

Gastric cancer remains one of the leading causes of mortality in the world. In developing countries, the incidence of gastric cancer has been steadily decreasing since the end of the Second War. Since 1996, she has been the second-biggest cause of death from cancer, with over 60000 deaths per year. The diagnostic age is between 65 and 74 years old. It is manifested in males, the ratio of males / females being between 1.5-4 / 1.

Generally patients with gastric neoplasm are long asymptomatic. If these symptoms occur, the most common manifestations of gastric and ulcer are: pain in the eyelid, heartburn, acid regurgitation or even vomiting.

As almost in all cancers, the symptoms of gastric cancer have an important feature: they progressively increase in intensity. Patients may experience signs of anemia (weakness, early fatigue, tegumentaraintensa, even fainting), weight loss, haematemesis and melena.

Gastric neoplasm is the 5th type of cancer in terms of frequency in Europe. It is twice more common in men than in women, and generally affects people aged between 60 and 80.(1)

Gastric cancers start insidiously, with blurred and inconsistent clinical signs, which is why it is often detected in advanced stages.(2)

Perforation represents a severe and rare complication of gastric cancer with a huge hospital mortality (8-82%).(3) Moreover, perforated gastric cancer is responsible for less than 1 % of cases of acute abdomen.(4)

Even that the incidence of gastric cancer has been declining (1), gastric cancer is the most frequent cause of gastrointestinal cancer and the second biggest cause of cancer-related mortality in the world.(5) In the other side, the spontaneous perforation of gastric cancer is a rare complication with very severe outcomes (1), which occurs in 0.56 to 3.9% of all cases of gastric cancer (6), with high rate of hospital

mortality (8-82%).(1) It is difficult to diagnose perforated gastric cancer, because its preoperative symptoms are the same as those of perforated gastric ulcer.(7,8)

Perforation of the stomach is one of the most frequent causes of the surgical acute abdomen.(2) In most of the cases gastrointestinal perforation is suspected based on certain clinical symptoms (high abdominal pain, abdominal rebound tenderness or muscular guarding, sometimes fever), and confirmed by imaging modalities including abdominal radiography, computer tomography. When acute abdomen due to gastrointestinal perforation is diagnosed, emergent surgery is necessary without further detailed preoperative examinations. The most frequent cause for gastro-duodenal perforation is gastro-duodenal ulcer, but only 10 % of the cases are caused by gastric cancer.(9)

Even intraoperatorily, it may be difficult to make the difference between a gastric ulcer from gastric cancer at the time of surgery, especially if an intraoperative frozen section is unavailable, except in cases with obvious metastatic tumours.(10)

CASE REPORT

We present the case of a 74-year-old female patient, known for hypertension, type 2 diabetes mellitus with oral antidiabetic medication, who was hospitalized in the Medical Ward for epigastric pain with retrosternal irradiation, having lost about 20 kg over the past 6 months, loss of appetite, onset of pathology of approximately 6 months.

Her medical history revealed that the patient was laparoscopically cholecystectomized on 06.07.2017, and the discharge summary revealed no gastric disorder. On November 18, 2017, the patient was hospitalized in another surgical ward of a city hospital for high-intensity diffuse abdominal pain, with signs of peritoneal irritation, therefore plain abdominal radiography was performed that revealed minimum

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Article received on 22.06.2018 and accepted for publication on 31.08.2018
ACTA MEDICA TRANSILVANICA September 2018;23(3):70-72

CLINICAL ASPECTS

pneumoperitoneum. Surgical intervention was performed under general anesthesia with tracheal intubation, by exploratory laparotomy which showed gastric perforation for which ulcer suture with epiploonoplasty was made with favourable postoperative evolution.

On the Medical Ward, upper digestive endoscopy in emergency was performed that highlighted an esophageal reflux, a stomach with ulcer on the lesser curvature towards the antral region covered by fibrin, with irregular edges and thickened folds for which biopsy was done; Abdominal CT highlighted gastric tumour mass on the lesser curvature with regional adenopathy (figure no.1).

Figure no. 1. Abdominal Computed Tomography

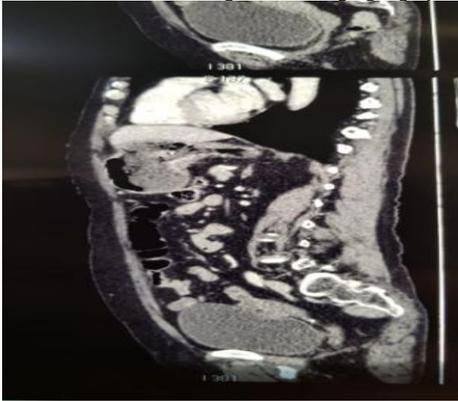


Figure no. 2. Tumour formation at the level of the lesser curvature invaded in the left hepatic lobe



Biochemistry: 11,000 leukocytosis, mild anemia, no other pathological changes.

The patient was transferred to the Surgery Clinic for specialized treatment.

Surgery was practiced on March 27, 2018 after a proper preoperative preparation, using exploratory laparotomy showing an adherence syndrome for which viscerolysis was practiced, revealing a tumour formation at the level of the lesser curvature invaded in the left hepatic lobe (figure no. 2) for which isolation of the tumour formation was decided, subtotal gastrectomy (figure no. 3) with entero anastomosis in Y a to Roux, D1/2 lymph node evidentment (figure no. 4) lavage, drainage, parietoraphy in anatomical layers.

Postoperative progression was favourable, balanced haemodynamic and respiratory status, with palpable, mobile abdomen, painless on palpation, permeable drainage tubes with minimal drainage, with their suppression on the 5th

postoperative day; intestinal transit resumed for faecal matter and gas on the 4th postoperative day, wound without reaction under healing.

Figure no. 3. Subtotal gastrectomy

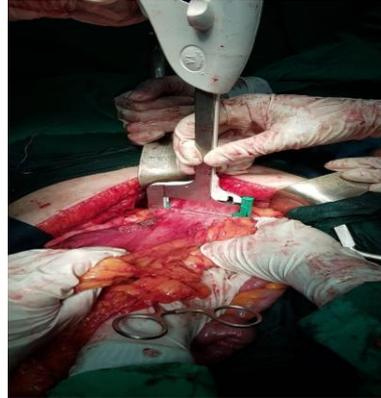
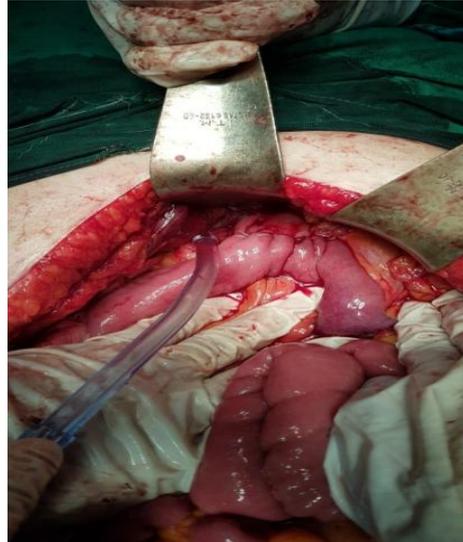


Figure no. 4. Entero anastomosis in Y a to Roux, D1/2 lymph node evidentment



DISCUSSIONS

The current concepts envisage a “multimodal” treatment adapted to each stage of a systemic disease. Breast cancer therapy includes at least three methods: surgical, medical, radiological.

In our case, although surgical treatment was radical by performing Madden modified radical mastectomy and axillary lymph node evidentment, the patient completely following all the post-operative chemotherapy sessions, this contralateral axillary recurrence occurred.

One can discuss about the appearance of relapse (reappearance, return of a disease after it has clinically healed, relapse.) or about remote metastasis (secondary localization away from the primary focus of a disease).

Taking into account that the patient was not considered to be cured after completing the multimodal treatment, we interpreted this contralateral axillary tumour as a distal metastasis of the primary tumour.

The histopathological result confirmed our hypothesis.

CONCLUSIONS

Gastric cancers start insidiously, with blurred and inconsistent clinical signs, which is why it is often found in

advanced stages. When there are symptoms, they are of the dyspeptic type: diffuse abdominal pain more pronounced in the epigastrium, abdominal meteorism immediately after eating, nausea, loss of appetite, pyrosis.

In advanced gastric cancer, clinical manifestations are systemic: melena, haematemesis, weight loss without an apparent cause, abdominal pain, palpitation of an epigastric tumour, jaundice, ascites.

In our case, the onset was atypical. The fact that the tumour was not identified either at the time of the laparoscopic cholecystectomy carried out 7 months before, or on the occasion of laparotomy for the perforated ulcer, placed us in front of a big dilemma.

There has been gastric cancer since the first operation, and the symptoms attributed to the gallbladder were only secondary, while the gastric perforation was actually a perforated ulcerative-vegetative gastric tumour or was an extremely aggressive gastric cancer that had developed rapidly over the last 5 months.

Taking into account the histopathologic aspects, the extra-serous development of the tumour with the left lobe invasion, but also the advanced stage we opted for the first variant.

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