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Isolated non-hepatic metastasis from upper gastrointestinal adenocarcinoma: A case for surgical resection

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ABSTRACT

INTRODUCTION: Upper Gastrointestinal Tract (UGIT) malignancy is an increasing problem in western society and its prognosis is generally poor. The prognosis dims even further with the presence of loco regional recurrences or distant metastasis. This article looks at the feasibility and potential benefit from resection of non-hepatic, non-nodal metastases and recurrences.

PRESENTATION OF CASE: Case 1. A 72-year-old male who underwent total gastrectomy for a gastric adenocarcinoma presented with a splenic mass 40 months later and underwent a splenectomy. He is disease free at 30 months post-metastectomy. Case 2. A 54-year-old male with oesophagogastric junctional adenocarcinoma, underwent an Ivor-Lewis oesophagectomy. He developed a distal pancreatic mass at 24 months follow-up and underwent distal pancreatectomy and splenectomy. He is disease free at 12 months post-metastectomy. Case 3. A 75-year-old male underwent subtotal gastrectomy for lesser curvature adenocarcinoma. At 42 months follow-up, he developed solitary abdominal wall recurrence. This was locally resected with clear margins. After 12 months, he developed another full thickness abdominal wall recurrence with involvement of the hepatic flexure. Enbloc resection including right hemicolectomy was performed and he is disease free at 3 months.

DISCUSSION: There is very scarce literature on resection of non-hepatic, non-nodal recurrences/distant metastasis in oesophagogastric cancers. Based on these cases, a surgical resection in selected cases may provide prolonged survival with good quality of life.

CONCLUSION: Resection for isolated recurrences and metachronous metastasis from UGIT cancers may be worthwhile, especially if patients have minimal co-morbidities.

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1. Introduction

UGIT malignancy is an increasing problem in western society. Generally, the prognosis for oesophageal and gastric cancers is poor at best.^{1,2} Gastric cancer is the 4th most common cancer worldwide³ and 11th in Australia.⁴ It is more common in men and has an incidence of 11.9 per 100,000 in men, 5.5 per 100,000 in women with a combined incidence of 8.7 per 100,000.⁴ Combined 5 year survival figures sit at 17.5%.⁵

Oesophageal cancer is the 8th most common in the world,³ and 15th in Australia,⁴ with an incidence of 5.8 combined and 8.4 and 3.1 per 100,000 population respectively for males and females.⁴ The 5-year survival for oesophageal cancer is a meagre 12.5% across all the stages.⁵

The poor prognosis that afflicts western patients is not mirrored in the East Asian population. The incidence of gastric cancer in East Asia is as high as 30 per 100,000⁶ but 5-year survival rates are up to 60% in some Japanese studies.⁶ Screening programmes and early diagnosis may be partly responsible for this difference. Literature from Japan suggests more radical surgery may be beneficial as well.⁶

While the results of the MAGIC trial,⁷ with perioperative chemotherapy, indicate an improvement in survival in the Stage 2 and 3 groups, the prognosis for M1 (AJCC) or Stage 4 disease still remains poor (4% five year survival) according to the AJCC.⁸ Metachronous recurrences and metastasis are seldom treated with curative intent and palliative chemotherapy or radiotherapy, if anything, is usually the preferred treatment modality.

Data on surgical resection of isolated metastases from UGIT malignancy is sparse with variable outcomes.^{9–12}

On this background we present three cases with good survival and quality of life after surgical resection of metachronous isolated non hepatic metastases form oesophago-gastric carcinomas.

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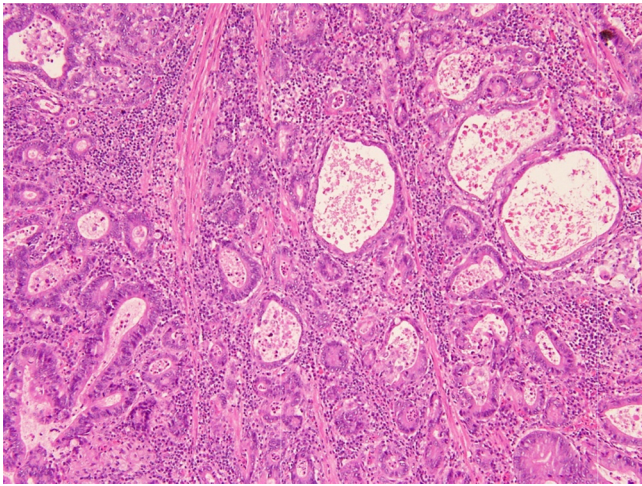


Fig. 1. Primary gastric adenocarcinoma.

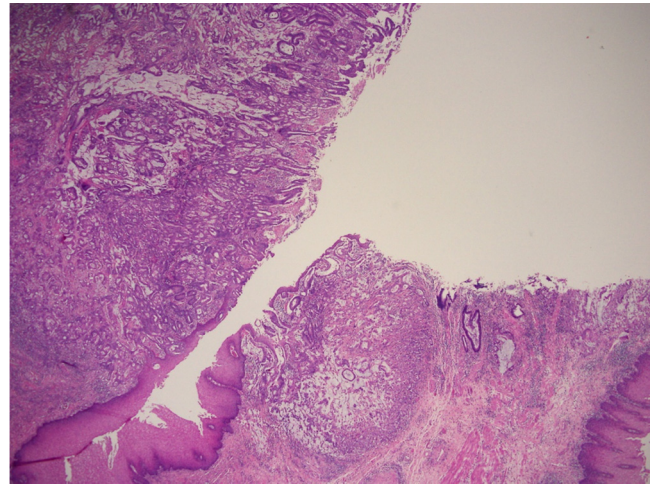


Fig. 3. Primary oesophageal adenocarcinoma.

2. Case presentation

2.1. Case 1

A 72-year-old male, on follow up after a total gastrectomy for a pT3 N0 proximal gastric cancer, was found to have a splenic mass on annual surveillance CT scan 40 months after the initial surgery. There was no evidence of any other metastases. Endoscopy was normal. The case was discussed at the unit multidisciplinary meeting (MDM) and a decision to perform an exploration with view to resection was taken in view of isolated nature of the possible metastasis. He underwent a laparotomy and splenectomy, which confirmed gastric carcinoma identical to that previously seen on the gastrectomy specimen. He was offered chemotherapy and declined. He has been followed in outpatients and at 30 months remains disease-free (Figs. 1 and 2).

2.2. Case 2

A 54-year-old male had previously undergone an Ivor-Lewis oesophagectomy after neoadjuvant chemo radiotherapy for a moderately differentiated pT3 N2 junctional adenocarcinoma starting at 36 cm from the incisors. This was on a background of DM and hypertension.

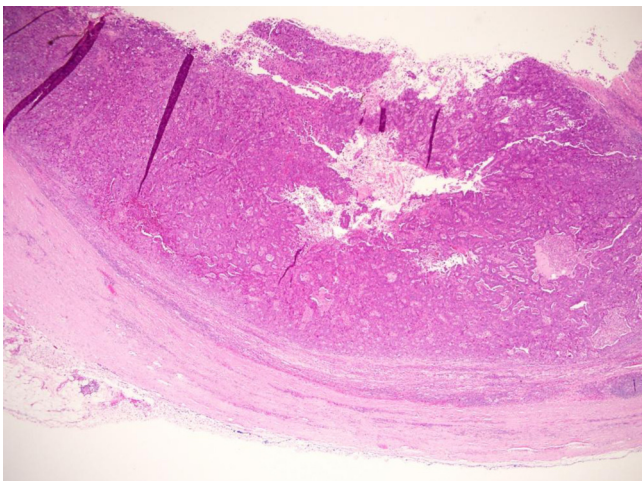


Fig. 2. Splenic metastasis.

At 24 months follow-up, he was found to have a 5 cm lesion in the tail of the pancreas on a CT scan. Further imaging was inconclusive as to the nature of the lesion. The case was discussed at the unit MDM and he subsequently underwent a distal pancreatectomy and splenectomy. Histology revealed this to be a mucinous adenocarcinoma in keeping with the previous oesophageal primary. There was extensive neural invasion. He recovered well initially but was readmitted with a small bowel obstruction a month after surgery and underwent further laparotomy. A single band adhesion was found and divided and he had an uneventful recovery after this. He underwent adjuvant chemotherapy and remains disease free at 12 months post-metastectomy (Figs. 3 and 4).

2.3. Case 3

A 75 year-old male had previously undergone a subtotal gastrectomy for a PT4 N2 gastric carcinoma. This was on a background of hypertension and mild asthma. He was given a course of adjuvant chemoradiotherapy.

He underwent follow-up as per unit protocol with regular clinical examinations and imaging. He presented to follow-up at 42 months with a lump in the abdominal wall in the right upper quadrant. Ultrasound revealed an intramuscular lesion invading anterior and posterior rectus sheaths, and a fine needle aspirate confirmed this to be adenocarcinoma .The lump, 25 mm × 20 mm × 25 mm

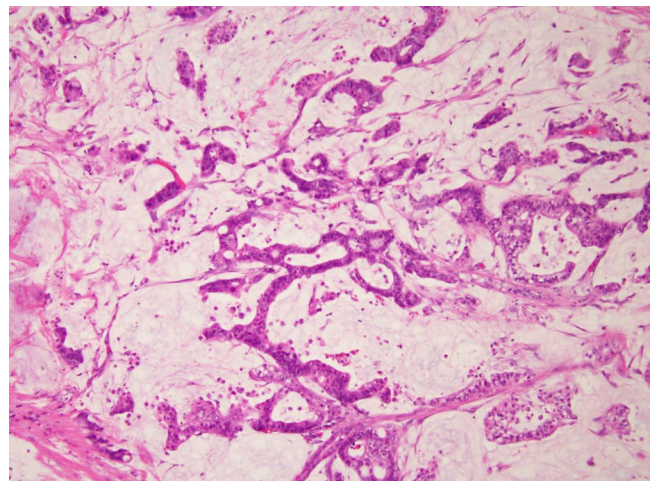


Fig. 4. Pancreatic metastasis.

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