

Letters to the Editor

Colonic metastasis of diffuse signet ring cells gastric carcinoma

Key words: Gastric cancer. Colonic metastases.

Dear Editor,

The gastric cancer, despite its remarkable decline in incidence (1), still remains as one of the leading causes of death around the world (2) (7.2 to 20 deaths per 10⁵ inhabitants per year) (3). The diffuse type (according to Lauren's classification) with signet ring cells occasional presence, is less frequent but with worse prognosis than the intestinal, both commonly spread out via haematic and lymphatic (40-60%), (4), and being able to affect organs such as the liver (35-50%), lung (9-22%), bone (1,9%), and central nervous system (0,5-2%); being exceptional, without references, the involvement of other organs such as the colon, as in the case of the patient we report.

Case report

This was a 58-year-old male with a history of thalassemia minor, sleep apnea and intervened by Nissen fundoplication due to the alterations of the intestinal transit, pruritus, anal sphincter disorders, and iron-deficiency anaemia. Among the tests that were carried out, colonoscopy demonstrated several ulcerated, vegetating, irregular, hard and brittle lesions located in the ileocecal valve, ascending colon and rectosigmoid junction. The pathology report indicated moderately differentiated adenocarcinoma infiltrating the cecum, colon, sigmoid, and rectum. By endoscopy, it

could be seen at the lower curvature of the stomach a large excavated ulcer of 4 cm from which biopsy was taken with the diagnosis of diffuse adenocarcinoma with signet ring cells.

Given these findings (Fig. 1), we contacted with the Department of General Surgery and a surgical intervention was programmed by performing total gastrectomy with D2 lymphadenectomy, splenectomy plus subtotal colectomy with ileorectal and jejunal esophagus anastomosis. The pathological study from the surgical specimens was informed as signet ring cells diffuse gas-



Fig. 1. CT scan with intravenous contrast of abdomen (image of lumino-gram). Thickening of gastric mucosa can be recognized. At ascending colon and splenic flexure and descending colon can be recognized a probable mass of irregular edges with rarefaction of the adjacent fat.

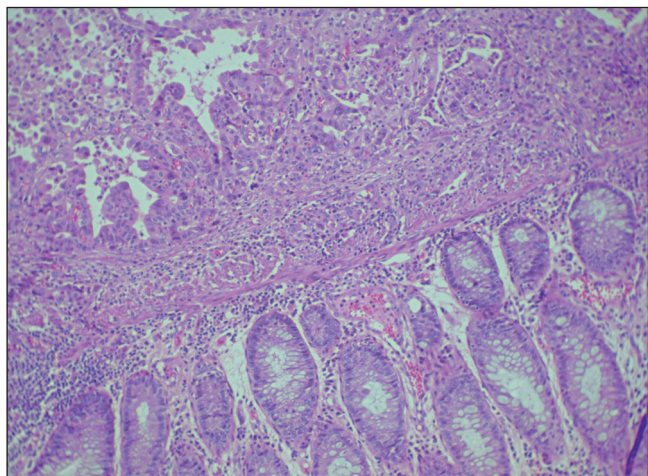


Fig. 2. Stain with haematoxylin-eosin of metastasis at the rectosigmoid union of a signet ring cells gastric cancer.

tric carcinoma with metastasis to the small and large intestines (Fig. 2), lymphatic dissemination at the celiac trunk, gastric curvature and periintestinal.

In the postoperative period, highlighted the presence of a subphrenic abscess and right pleural effusion, which required drainage by interventional radiology. Upon a month of entry, the patient was discharged from revision care and was registered for the nutrition, surgery and oncology service, where he received palliative chemotherapy —preplacement of a reservoir— with cisplatin, a weekly dose during the period of one month. He died upon completing a year of post-surgery.

Discussion

In our country, the annual incidence of gastric cancer is estimated to be at around 15-20 cases per 10⁵ inhabitants per year (8.6% of all new cases of cancer). The most common form of presentation is adenocarcinoma of the bowel type variant (3,5). The histological diffuse form (according to Lauren-Ming classi-

fication) with signet ring cells such as the one showing by our patient corresponds to the 3 to 39% of all gastric cancers (6), is known to affect young people with predominant blood group A, with no association with premalignant lesions, low relation to environmental factors, badly differentiated and displaying a higher lymphatic impairment (7). Colonic impairment is exceptional by haematological dissemination (8), as in the case we have described. We have found scarce references on this topic.

María Luisa Reyes-Díaz, Cristina Torres-Arcos,
Fernando Oliva-Mompeán, Antonio Curado-Soriano,
Claudio José Lizarralde-Gómez and Francisco Cuaresma-Soriano

*Clinical Management Unit. Hospital Universitario
Virgen Macarena. Sevilla, Spain*

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