

asis preferentially of the right lower extremity. The causal gastric cancer had not been identified for 2 years until the fourth gastroscopy assisted by endoscopic ultrasonography revealed the lesion. No regional lymph node metastases were found while distant inguinal lymph nodes were already involved.⁵ In another study of 2,232 patients with inguinal node metastasis, only one was found to be due to spread from primary gastric cancer.⁶

In conclusion, inguinal metastasis from gastric cancer is rare, and rarer still is an asymptomatic presentation. The occlusion of loco-regional and para-aortic lymph nodes in gastric cancer would naturally redirect the lymphatics through alternative pathways, resulting in retrograde dissemination and aberrant metastasis.

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Adjuvant Colon Cancer

Perforation and Stage-II Colon Cancer: Is it Always High Risk?

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CASE REPORT

A 52-year-old woman presented with acute abdominal pain. She was otherwise in good health, and her past medical history was unremarkable. Her family history was significant only for non-small-cell lung cancer; no members had colorectal malignancies or polyps. Computed tomography (CT) scans revealed a large pelvic abscess, vague thickening of the sigmoid, and diverticular disease. She subsequently underwent surgery for perforated diverticulitis. The abscess was drained, and low anterior resection performed. Extensive peritonitis was evident throughout the bowel.

During the procedure, a non-inflammatory 5 cm, sigmoid mass was discovered. Pathology revealed a well-differentiated adenocarcinoma, with tumor extending to fat. Surgical margins were negative and angiolymphatic invasion was not demonstrated. Eighteen of 18 resected nodes were negative for malignancy. Of note, the patient had a perforated diverticulum located proximal to the mass and clearly not extending through the tumor. The pathology reported confirmed that the tumor itself was not associated with the perforation. The patient was subsequently informed by her oncologist that she would require 6 months of chemotherapy. She does not want to undergo chemotherapy.

DISCUSSION

This case raises a number of questions regarding the most appropriate course of treatment. Is perforation always considered a

“high-risk” situation warranting adjuvant chemotherapy? There is no doubt that a patient with a perforation through tumor should receive adjuvant chemotherapy. In this case, however, in which the perforation did not involve the tumor, in the absence of any other “high-risk” clinical markers, should the patient still be classified as having high-risk stage-II disease and go on to receive adjuvant chemotherapy? And if so, which treatment would be most beneficial?

Perforation has long been described as making stage II colon cancer high risk for recurrence. However, the location and type of perforation that truly increases risk has not been detailed. Prior Intergroup study eligibility for patients to potentially receive chemotherapy ranged from “perforation causing emergent presentation” to “any bowel perforation” to the specific requirement for there to be “perforation through tumor.” An International Society of Gastrointestinal Oncology (ISGIO) Consensus Statement merely said “tumor perforation” makes stage II disease high risk.¹

Additionally, few available data actually look at which chemotherapy to give to patients with proven high-risk disease. The MOSAIC (Multicentre International Study of Oxaliplatin/5-Fluorouracil-Leucovorin in the Adjuvant Treatment of Colon Cancer) Trial compared 5-fluorouracil (5-FU)/leucovorin (LV5FU) vs. FOLFOX4 (oxaliplatin + LV5FU2) in the adjuvant treatment of stage II and III colon cancer.² A subset analysis of that study looked at high-risk, stage II patients. High-risk stage II was defined as the presence of at least one of the following characteristics: T4 invasion,

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tumor perforation, clinical bowel obstruction, poorly differentiated tumor, venous invasion, and <10 lymph nodes examined. The difference in disease-free survival at 3 years was 5% in favor of FOLFOX4; at 5 years, the difference was 7.2% in favor of FOLFOX4. The differences, however, did not reach statistical significance.

In conclusion, the risks associated with perforation are not well-defined. Other risk factors such as obstruction are better characterized; specifically, clinical bowel obstruction is required (radiologic observations are not as meaningful). In general, risk factors are, for the most part, prognostic; it is not yet clear that they are predictive. Specifically, we do not know that they mandate treatment, we only know that patients do worse in the presence of such risk factors. In

time, molecular markers are likely to emerge as aides in determining risk of recurrence in patients lacking clinical markers.

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The author indicated no potential conflicts of interest.

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The total length of the body text (**CASE REPORT** and **DISCUSSION**) should not exceed four to five double-spaced pages. Figures must be described and called out in text. In photographs, sonograms, CT scans, etc, the physical identification of a patient should be masked whenever possible. It is the author's responsibility to comply with applicable privacy laws and to obtain a HIPAA-compliant patient authorization if the case report or the image includes individually identifiable health information.

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