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Carcinoma of the stomach: an unusual pattern of metastasis

Carcinoma of the stomach has decreased in incidence in North America but still is the sixth most common gastrointestinal malignant tumour.[1] The 5-year survival rate is only 15% to 20%.

We report a case in which a metastatic deposit to the patient's anterior abdominal wall and then to the left axilla developed after gastrectomy for carcinoma of the stomach.

The patient, a 75-year-old man, underwent a distal gastrectomy with Billroth II anastomosis for carcinoma. Pathological examination of the operative specimen showed a poorly differentiated adenocarcinoma invading through the muscularis propria. Two of 6 lymph nodes were positive for malignant cells. Fifteen months later the patient was seen with an abdominal midline mass measuring 7×9 cm. CT showed a mass in the abdominal wall and no evidence of any metastatic disease within the abdominal cavity. At operation under general anesthesia, the abdominal wall mass was excised. The pathological findings were of metastatic carcinoma similar to the previously resected gastric cancer. Five months later the patient presented with a mobile mass in the left axilla, 7 cm in dimension. CT revealed a solid mass, which was excised (Fig. 1). It was a poorly differentiated metastatic carcinoma similar to the previously excised abdominal wall mass. CT of the pelvis, abdomen and chest, 1 month after axillary surgery did not reveal any evidence of metastatic disease.

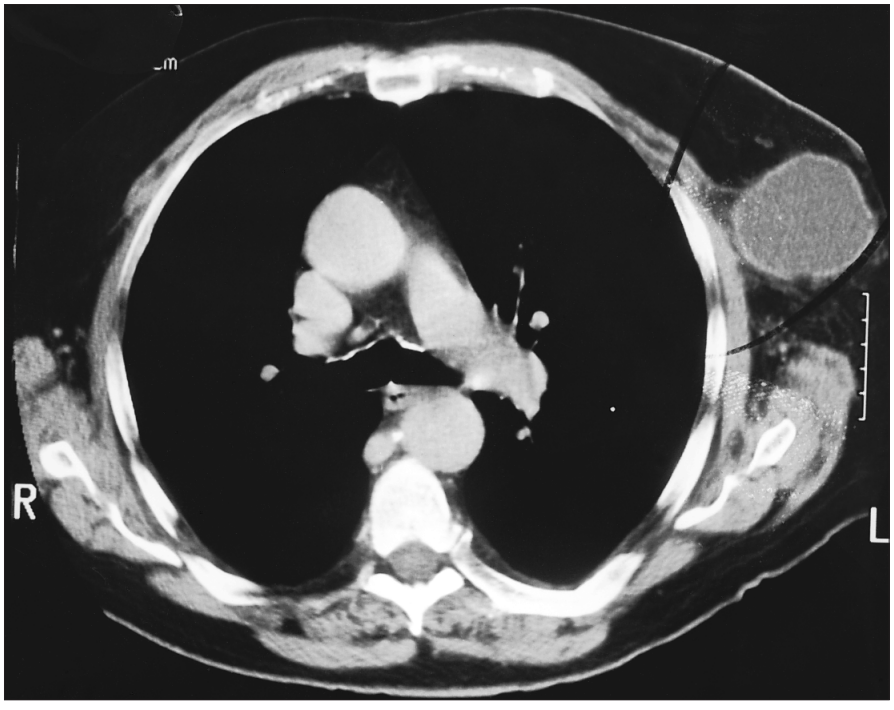

FIG. 1. CT scan shows metastatic mass in axilla from carcinoma of the stomach.

Patterns of metastasis in gastric cancer have been extensively studied and reported in the literature. The 3 principle mechanisms of gastric tumour spread are by direct extension, lymphatic spread and vascular dissemination. Gastric tumours characteristically progress by local extension through the gastric mucosa, submucosa, muscularis propria and subserosal tissues into surrounding organs and the peritoneal cavity. Direct extension may involve pancreas, splenic hilum, transverse colon, hilum of liver, omentum, diaphragm and esophagus. Gastric tumours are also capable of spreading intramurally beneath an apparently normal gastric mucosa. We did not find any specific reports of isolated metastatic spread of gastric adenocarcinoma to abdominal wall or axilla.

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Reference

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