

Case Report

Synchronous dual primary gastric and colon cancer – an uncommon entity

Pradhan S, Kharel A, Lakhey PJ, Singh KP

Department of Gastrointestinal and General Surgery, Tribhuvan University Teaching Hospital

Correspondence to: Dr. Sumita Pradhan

E-mail: sumiepradhan@gmail.com

Abstract

The incidence of multiple primary malignant neoplasms is said to increase with age and the occurrence of a second malignancy in a patient with a known malignant tumor are not uncommon. They are being encountered mainly because of an improvement in diagnostic techniques and prolonged survival of patients treated for malignancy. However this phenomenon is still considered to be rare. Herein, we present a case of synchronous gastric and ascending colon cancer treated in our centre.

Keywords: Synchronous dual primary cancer, gastric cancer, colon cancer

Introduction

The incidence of multiple primary malignant neoplasm increases with age. They are being encountered - due to improvements in diagnostic techniques and prolonged survival of patients treated for malignancy.¹ According to the literature, the overall occurrence rate of the multiple primary malignant tumors (MPMT) is estimated between 0.73 and 11.7 % and has been defined as two or more different synchronous or metachronous cancers in the same or different system.² In our institute, retrospective review of records of 73 cases that underwent surgery for gastric cancer from Jan 2013 to Feb 2016 revealed a single case of synchronous dual primary.

Case presentation

We report a case of a 70 year lady, non smoker and a diabetic who was evaluated for epigastric pain of 7 months duration, associated with anorexia, weight loss and occasional constipation. Endoscopy revealed an antral ulcer whose biopsy came out to be a poorly differentiated adenocarcinoma. Cect of the abdomen

and pelvis reported 8mm mucosal thickening in antrum likely gastric cancer with circumferential wall thickening of ascending colon with pericolic fat stranding suggestive of ca colon.

Colonoscopy reported malignant looking stricture in ascending colon, whose biopsy came as poorly differentiated adenocarcinoma. Intra operative findings (figure 1 and 2) revealed a 2cm wide circumferential growth in antrum of stomach with 4 X 4 cm ulcer-proliferative lesion in ascending colon. There were multiple enlarged lymph nodes along vessels at celiac axis. There were no ascites, liver or peritoneal metastasis. D2 subtotal gastrectomy with extended right hemicolectomy was done and patient discharged with uneventful recovery. Her final HPE reported, stomach lesion as a moderately differentiated tubular adenocarcinoma, T1bN2 and colon as a poorly differentiated adenocarcinoma, T3N2b. patient was planned for adjuvant therapy and currently receiving FOLFOX regimen. She has completed 8 cycle chemotherapy and is planned for 9th cycle and doing well on follow up.

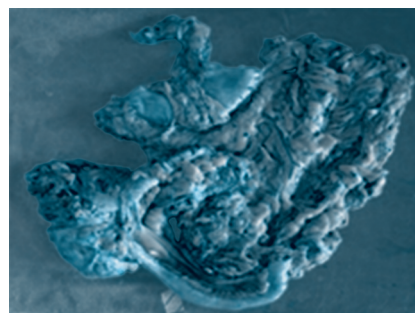
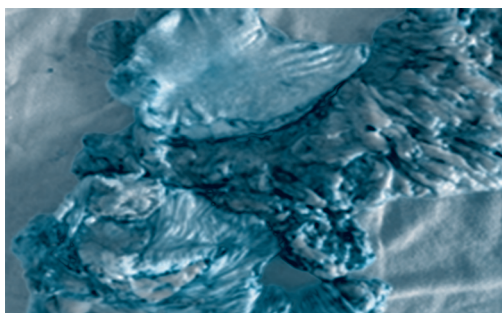


Figure 1 and 2

Discussion

Warren and Gates defined synchronous carcinoma as malignancy histopathologically proven, lesions clearly differentiated and locally isolated, and possibility that one of the tumors is metastatic must be excluded.³ Synchronous tumors of various sites has been described like larynx and the stomach, stomach and the duodenum, stomach and the colon and stomach, the gall bladder and colon. The most common form of synchronous digestive tract tumor is colorectal (CRC) and gastric cancer (GC) (4%).⁴

Etiology has been attributed to genetic and environmental relations.⁵ Surgical resection with D2 lymphadenectomy represents the standard treatment and simultaneous resection is indicated for all cases.⁶ According to Ikeda et al, the 10-year survival rate was 40.1% for synchronous double primary cancer.⁷ Although double primary gastric cancer associated with colon cancer in patients are very rare, the possibility of synchronous lesions should not be overlooked.

Conclusion

Dual primary gastric and colon cancer is an uncommon entity. High index of suspicion is required to rule out synchronous lesions. Combined resection should be applied whenever possible.

Conflict of interest: None declared

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