Case 56 A serious gastric lesion

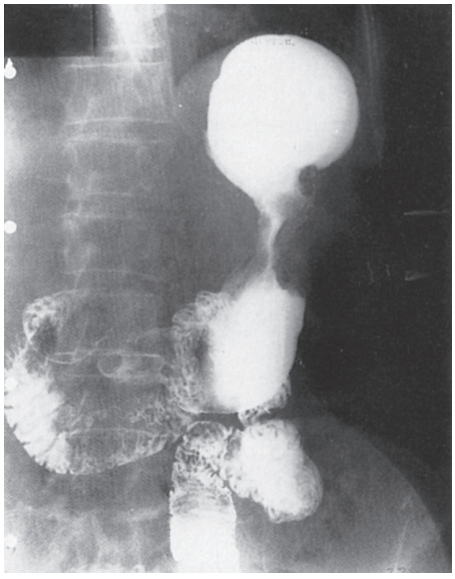

Figure 56.1

A 59-year-old supermarket manager presented with a short history – 4 or 5 months – of epigastric discomfort after meals, loss of appetite and loss of weight, which had dropped from its normal 75 kg to 68 kg. He had no discomfort at night. He had tried various proprietary indigestion remedies, but none had helped him. When examined by his medical practitioner, he looked pale and had obviously lost weight. Examination of the abdomen revealed some epigastric tenderness, but no masses could be felt. There was no hepatomegaly or clinical ascites. The supraclavicular nodes were impalpable and rectal examination was clear. The physician arranged for his patient to have an urgent barium meal examination. The appearances of the deformity in Fig. 56.1 were constant throughout the X-ray series.

Describe what this patient's X-ray demonstrates

There is a constant elongated narrowing, or stricture, occupying the body of the stomach. The fundus appears normal and there is free flow of barium into the duodenal loop.

Putting the clinical features and the X-ray appearances together, what is your working diagnosis?

Carcinoma of the body of the stomach.

What is the obvious next step to be carried out in the investigation of this patient to confirm or refute this diagnosis?

Urgent gastroscopy and biopsy of any suspicious area seen. This was done, and a malignant ulcer seen, almost encircling the body of the stomach. Examination of the multiple biopsy specimens taken showed a rather poorly differentiated adenocarcinoma.

Note that nowadays fibreoptic oesophago-gastric endoscopy is the screening investigation of choice in patients such as this, where a peptic ulcer or malignancy is suspected clinically. It is an interventional and uncomfortable investigation with a small risk of complications, such as perforation, compared with merely swallowing some flavoured clear fluid, but it has a high degree of sensitivity and specificity and allows an immediate biopsy to be taken of any suspicious lesion. The alternative would be a CT scan with oral contrast which would show thickening of the stomach wall at the site of the tumour. We have kept these images in the text since the barium studies give a good appearance of the effects of the tumour on the appearance of the stomach.

*Charles Emil Troisier (1844–1919), Professor of pathology, Paris.

What clinical evidence would you seek of lymphatic spread of this tumour?

Palpation of the supraclavicular fossa for enlarged supraclavicular nodes spread along the thoracic duct (Troisier's sign,* signifying involvement of Virchow's node†). Note that his clinician was careful to perform this step in his examination of the patient.

What abdominal signs would you look for that would indicate portal vein and transcoelomic spread?

- *Portal vein spread*: Enlargement of the liver with or without jaundice together with ascites due to raised portal pressure.
- *Transcoelomic spread*: Ascites due to exudation from peritoneal seedings of tumour.

Note, in addition, that in the female patient a pelvic examination may reveal bilateral ovarian masses due to transcoelomic deposits of tumour (Krukenberg's tumour‡).

†Rudolf Virchow (1821–1901), Professor of pathology, Wurzburg and then Berlin.

‡Friedrich Krukenberg (1871–1946), pathologist, Halle, Germany.