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A Silent Gastric Adenocarcinoma With Peritoneal Carcinomatosis: A Case of a Newly Diagnosed Decompensated Cirrhosis Leading to a Fatal Diagnosis of a Silent Metastatic Malignancy

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Introduction

➢Gastric carcinoma (GC) with peritoneal carcinomatosis is an advanced cancer with a median survival of less than 6 months.

➢It is the third leading cause of cancer-related death.

➢We present a case of an advanced Gastric Signet-ring cell carcinoma (GSRCC) with peritoneal carcinomatosis that presented as decompensated liver cirrhosis.

Case Description

➢A 62-years-old African American male with HTN and DM type II presented with 4 week of worsening abdominal distension with pressure and worsening acid reflux.
➢He denied alcohol, smoking and has no family history of gastrointestinal malignancy.
➢Physical exam revealed a non tender but distended abdomen with dullness to percussion.
➢CT scan of abdomen and pelvis (CT A/P) revealed liver cirrhosis and moderate ascites with mesenteric edema.

➢EGD revealed small varices and poor distensibility of the stomach with diffuse mucosal congestion, granularity, ulceration and abnormal mass in the gastric body and antrum (Figure 2).
➢Biopsy uncovered poorly differentiated GC with signet ring cells.

➢Repeat CT A/P with contract revealed nodular densities in the omentum with ascites (Figure 1).
➢Ascitic fluid cytology also confirmed adenocarcinoma with positive CK7 and CDX-2 markers.

➢With the aforementioned test results, diagnosis of GSRCC stage P3 was made and he was started on palliative chemotherapy with mFOLFOX6 (modified folinic acid, fluorouracil, and oxaliplatin).

➢Hospital course was complicated by acute PE with RV strain and small bowel obstruction.

➢He is done with 14 cycles of Chemotherapy with FOLFOX and 3 cycles of Xeloda maintenance chemotherapy.

➢He has declining functional status and multiple readmission but is alive 14 months post diagnosis of metastatic gastric cancer.

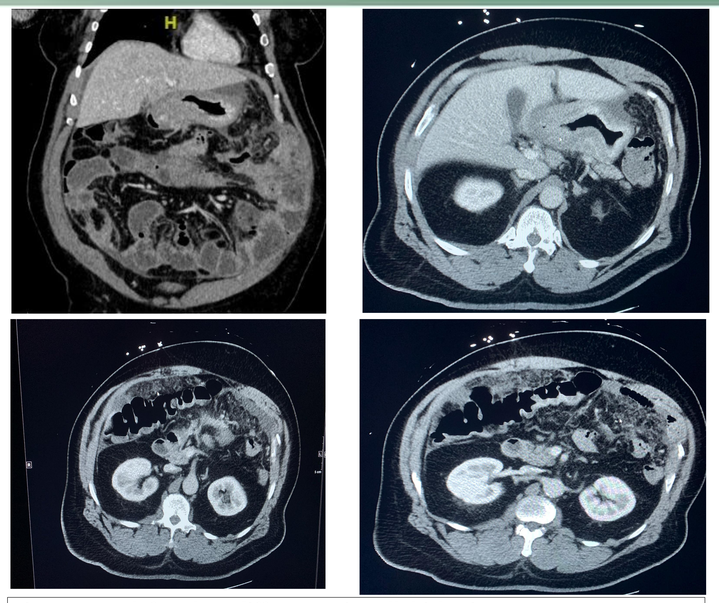

Figure 1: Top left and Rt: diffuse gastric wall thickening
Bottom Left and Rt: Omental nodularities concerning for metastasis

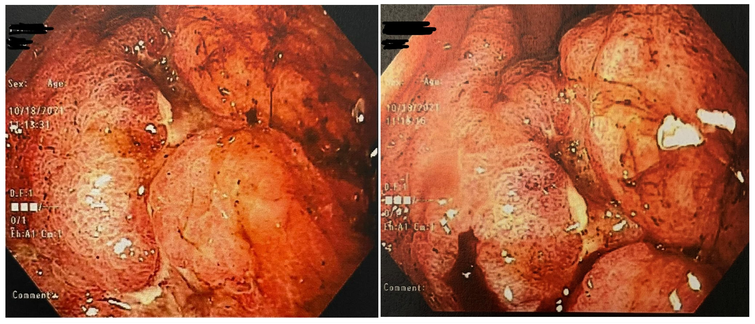

Figure 2: Abnormal mass in gastric antrum and pre-pyloric region

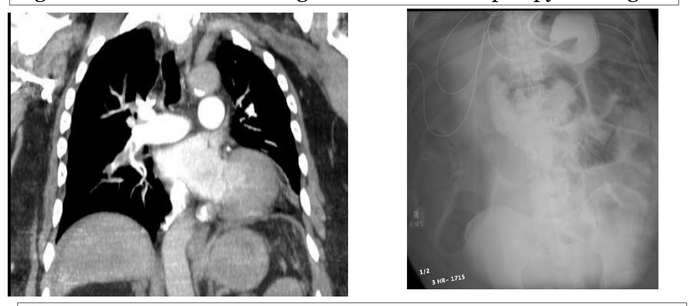

Figure 3: Left: Acute PE RLL; Right: SBO w/no contrast in distal bowel.

Discussion

➢Most GC are diagnosed at advanced and incurable stage with a median survival of 6 months hence early diagnosis is key to increased survival.

➢The only potential curative therapy is surgical resection for GC in situ whereas palliative chemotherapy is the probable therapeutic option for intraperitoneally-disseminated GC.

➢Based on multiple retrospective studies, gastrectomy with systemic palliative chemotherapy did not significantly improve survival when compared to chemotherapy alone in intraperitoneally-disseminated GC.

➢With rising in GSRCC cases, general population should be educated about its early signs and should seek medical attention sooner.

➢Physicians likewise should have a low threshold for referring to gastroenterologist for endoscopy in a high-risk patient with any alarm symptoms or for persistent acid reflux or epigastric pain that is not relieved with a trial of PPI.

➢Our patient had acid reflux for more than a year which was mildly controlled with antacid.

➢Had he sought appropriate medical attention, his diagnosis could have been made at an earlier stage.

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