

GASTROİNTESTİNAL SİSTEMİN SENKRON VE METAKRON MALİGN TÜRÖRLERİ

SYNCHRONOUS AND METACHRONOUS MALIGNANT TUMORS OF THE GASTROİNTESTINAL TRACT.

Müfide Nuran AKÇAY, Durkaya ÖREN, Cafer POLAT, Cemal GÜNDOĞDU
Saadettin ÇELİK

Atatürk Üniversitesi Tıp Fakültesi Genel Cerrahi (MNA, DÖ, CP, SÇ) Patoloji (CG) Anabilim Dalı, Erzurum

Özet

Gastrointestinal sisteme ait herhangi bir organda multipl malign tümörlerin ortaya çıktığı bilinmektedir. Bunun yanı sıra abdominal organlardaki malign tümörler, vücudun herhangi bir kısmındaki malign tümörlere eşlik edebilir. Bu makalede son 5 yıldır karşılaştığımız 3 senkron, 3 metakron kanseri sunuyoruz.

Anahtar kelimeler: *Senkron malign tümör; Metakron malign tümör.*

Summary

Multiple malignant tumors in one organ are known to occur in different parts of the gastrointestinal tract. Besides, malignant tumors of the abdominal organs may accompany to the malignant tumors found in an other part of the body. We present here 3 cases of synchronous and 3 cases of metachronous cancers encountered over 5 years.

Key words: *Synchronous malignant tumor, Metachronous malignant tumor.*

AÜTD 1997, 29:414-417

MJAU 1997, 29:414-417

Introduction

The criteria for multiple cancers, defined in 1932 by Warren and Gates and later by Moertel, have remained unchanged to this day: Multiple primaries are defined as a coexistence or succession of two or more distinct malignant tumors separated by normal mucosa and possibly found in the same organ. In addition: 1. The histology of each tumor must be positive; 2. One tumor must not be the metastasis of another cancer; 3. Locoregional lymph node metastases and distant metastases must be excluded, and cancerous localizations must be separated by at least 1.5 cm intervening normal mucosa (1-4). The time of discovery of the cancers permits formulation of a more precise terminology: Simultaneous cancers are discovered at the same time or within a period of less than 1 month from each other; synchronous cancers are discovered within a period of 6 months after the first primary; and metachronous cancers are discovered more than 6 months after the first primary (1, 2) We present here 3 cases of synchronous and 3 cases of metachronous cancers encountered over 5 years.

Case Reports

Case 1

The patient was a 60-year-old woman who had been operated with the diagnosis of acute mechanical intestinal obstruction. Colonoscopy could not be performed because of the patient ' s urgency. On

exploration, two tumors were found, one at the rectosigmoid junction and the other at the hepatic flexure. Perforation was observed in the first tumor, and the latter did not completely obstructed the lumen. So, anterior resection and hartmann procedure were performed . Fifteen days later, the patient was reoperated, and after colostomy was closed, right hemicolectomy was performed. Pathologic diagnosis of the tumor found at the rectosigmoid junction was adenocarcinoma, and pathologic diagnosis of the second tumor was mucinous adenocarcinoma. The patient was discharged on the 10th postoperative day. Chemotherapy was planned for the patient by Medical Oncology Clinic.

Case 2

A 70-year-old male patient, who had undergone prostatectomy because of prostatic carcinoma (pathologic diagnosis was in situ prostatic adenocarcinoma) 8 months ago, was reoperated with the diagnosis of acute abdomen. On exploration, there were total small and large bowel gangrene and a malignant lesion in the cardiac region of the stomach. Biopsy was taken from that lesion. Pathologic diagnosis was adenosquamous cell carcinoma. Any surgical procedure was not performed for gangrene because of the extensiveness of the disease. The patient died on the second postoperative day.

Figure 1-a. Adenocarcinoma Located at the Rectosigmoid Junction (HEx100)

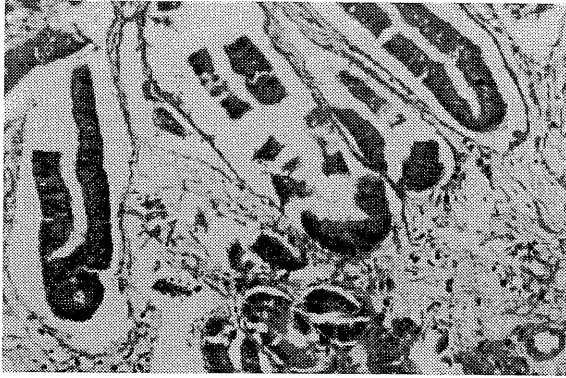
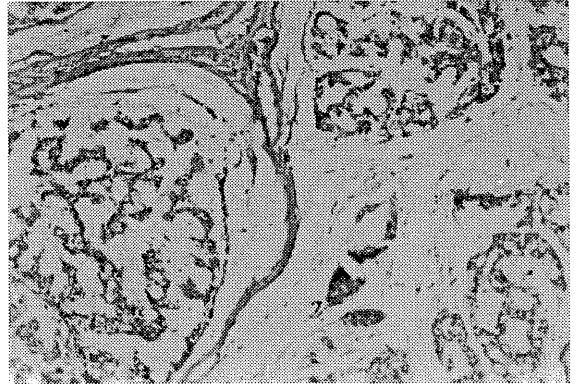


Figure 1-b. Mucinous Adenocarcinoma Located at the Hepatic Flexure (HEx100)



Case 3

A 51-year-old male patient, who had been operated because of a mass in the left gluteal region 1 year ago (pathologic diagnosis was rhabdomyosarcoma), was reoperated with the diagnosis of pancreatic head carcinoma. The tumoral mass was regarded as nonresectable, and a palliative bypass procedure was performed along with a biopsy taken from the head of the pancreas. Pathologic diagnosis was lymphoma. The patient was discharged on the 10th postoperative day.

Case 4

71-year-old male patient was hospitalized with the diagnosis of gastric cancer (adenocarcinoma) (Fig. 2-a). He had many urinary complaints. Sistoscopy with biopsy demonstrated a transitional cell carcinoma in the bladder (Fig. 2-b). After gastric resection, the patient was transferred to Urology Clinic.

Case 5

A 73-year-old male patient with a history of non-Hodgkin lymphoma diagnosed 5 years ago, was operated with the diagnosis of mechanical intestinal obstruction. On exploration, a tumoral mass of which pathologic diagnosis was adenocarcinoma was found at the rectosigmoid junction. Anterior resection was performed. He was discharged on the 14th postoperative day. Chemotherapy was planned for the patient by Medical Oncology Clinic.

Case 6

The patient was a 55 - year - old woman who had been hospitalized with the diagnosis of an obstructive malignant lesion in the sigmoid colon found on colonoscopy. The malignant lesion was resected. On exploration the other intraabdominal and pelvic organs were normal. Pathologic diagnosis was mucinous adenocarcinoma. Postoperatively, the patient had no problem and was discharged on the 10th postoperative day. The patient was readmitted with complaints of abundant vaginal bleeding and an intraabdominal mass 2 months later after the first operation. Reexploration revealed a left semisolid ovarian mass with dimensions of 15x15 cm. Frozen section was reported as a malignant lesion. So, total abdominal hysterectomy and bilateral salpingoophorectomy were performed. Pathologic diagnosis of the specimen was embryonal carcinoma of the left ovarium. Three months later, the patient was reoperated with the diagnosis of mechanical intestinal obstruction. On exploration diffuse brids and an appearance of carcinomatosis peritonei were observed. We achieved to perform only ileostomy. The patient died on the 10th postoperative day.

Discussion

Multiple malignant tumors in one organ are known to occur in different parts of the gastrointestinal tract. Besides, malignant tumors of the abdominal organs may accompany to the malignant tumors found in an other part of the body (1,5). Between 3 and 7 per cent of patients who have a carcinoma of

Figure 2-a. *Gastric AdenoCarcinoma (HEX100)*

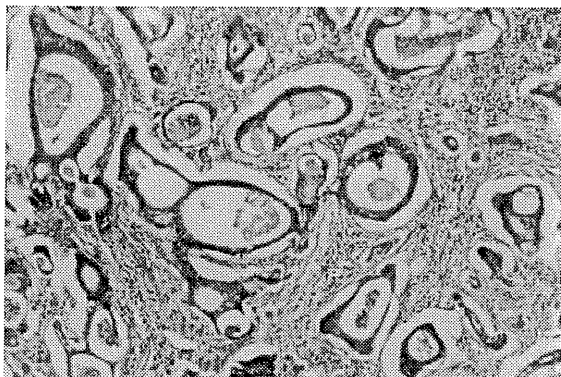
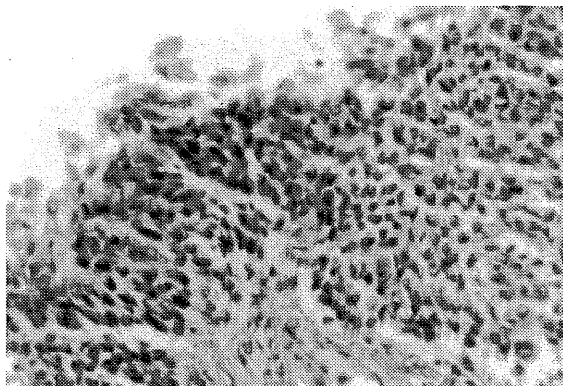


Figure 2-b. *Transitional Cell Carcinoma in the Bladder (HEX100)*



the colon or rectum will have a second synchronous carcinoma in the colon or rectum (6). The reported incidence of a colonic neoplasm presenting with a synchronous extra - colonic second primary is between 1 and 7 per cent. The most common of these tumors are those found in the skin, breast, stomach, bladder, and prostate (7). Mainwaring et al (7) reported a patient with a synchronous hepatocellular carcinoma and adenocarcinoma of the colon. Pancreatic carcinoma is multicentric in as many as 31 % of cases, and multicentric esophageal squamous cell carcinomas, encountered in 80 % of cases in one series, are frequent enough to be classified separately (1). Multiple malignant tumors of the bile ducts are rare, and Gertsch et al (1) have reported 5 cases in addition to 13 cases reported in the literature. Synchronous cancers have a very poor prognosis, characterized by an extremely aggressive, plurifocal cancerization. The 5-year actuarial survival rate is 18 per cent, with variations according to treatment. Metachronous cancers represent a very different type of disease with a much better prognosis (5 - year actuarial survival rate of 55 per cent) (2). Two of the 6 patients in our study died (mortality rate is 33.3 %). One of the fatalities had synchronous, and the other had metachronous tumor. A topographical study of the occurrence of multiple cancers indicates that synchronous cancers occur in anatomical localizations near the first cancer, as it was in our 6th case (2). While a number of studies have reported the synchronous carcinomas to be more

common in the adults than older ones, many others have reported them to be more common in the older patients (8). All of our patients were older than 50 years old, and 3 were older than 70 years old. It has been reported that the patients with synchronous colon carcinoma have benign neoplastic polyps at a higher rate. This fact is consistent with the idea that colon carcinomas arise from colon polyps (8). The patients with a colon cancer need to be evaluated by means of both colonic and extra-colonic synchronous tumors. Because colonic tumors are the most frequent tumors found with other colonic and extra-colonic tumors. Of our cases, case 1 had multiple colon tumors, and cases 5 and 6 had colonic tumors with extra-colonic secondaries. Colonoscopy seems to be the most reliable method for detection of synchronous colorectal cancer. Besides, colonoscopy is further recommended at intervals of 12-18 months during follow up (9,10). Extra - colonic areas must be investigated with various diagnostic procedures. If a second cancer is discovered just after the treatment of a first cancer, the implementation of a second therapeutic phase runs into major difficulties. These tumors existed before the treatment, but were not detected during the pretherapeutic examination (2,11). As a result, the patients with a colon cancer or another abdominal malignant tumor must be evaluated by means of both colonic and extra-colonic synchronous tumors. When they are diagnosed preoperatively, not only change the surgeons' operative strategy, but also prevent the patients' bad outcome.

References

1. Gertsch P, Thomas P, Baer H, et al: Multiple tumors of the biliary tract. *Am J Surg* 1990; 159: 386 - 388.
2. Panosetti B, Luboinski B, Mamelle G, Richard JM: Multiple synchronous and metachronous cancers of the upper aerodigestive tract: A nine - year study. *Laryngoscope* 1989; 99: 1267 - 1273.
3. Kodner IJ, Fry RD, Fleshman JW, Birnbaum EH. Colon, rectum and anus. In: Schwartz SI, Shires GT, Spencer FC (eds). *Principles of Surgery*. New York: McGraw-Hill Book Company, 1994: 1191-1301.
4. Evers BM, Mullins RJ, Matthews TH, et al: Multiple adenocarcinomas of the colon and rectum: an analysis of incidence and current trends. *Dis Colon Rectum* 1988; 31: 518 - 522.
5. Langevin JM, Nivatsungs S: The true incidence of synchronous cancer of the large bowel. *Am J Surg* 1984; 174: 330 - 333.
6. Leaper DJ. Tumors of the colon. In: Schwartz SI and Ellis H (eds). *Maingot ' s Abdominal Operations*. East Norwalk : Appleton and Lange, 1990: 1033-1047.
7. Mainwaring RD, Rivera J, Wilson W: Synchronous hepatocellular carcinoma and adenocarcinoma of the colon. *Am Surg* 1989; 55: 528 - 532.
8. Gülter N, Genç H, Örsel A, Çökmez A, Deniz S, Akaoğlu C: Senkron kolon karsinomu. *Cerrahi Tıp Bülteni* 1995; 1: 47-49.
9. Barillari P, Ramacciato G, De Angelis R, et al: Effect of preoperative colonoscopy on the incidence of synchronous and metachronous neoplasms. *Acta Chir Scand* 1990; 156: 163 - 166.
10. Isler TJ, Brown PC, Lewis FG, Billighan RP: The role of preoperative colonoscopy in colorectal cancer. *Dis Colon Restum* 1987; 30: 435 - 439.
11. Fegiz G, Ramacciato G, Barillari P, et al: Surgical treatment of metachronous colorectal cancer. *Int Surg* 1988; 71: 16 - 18.

Correspondence:

Yrd. Doç. Dr. Müfide Nuran AKÇAY
Atatürk Üniversitesi Tıp Fak.
Genel Cerrahi Anabilim Dalı
Erzurum