Duodenal stump recurrence of gastric adenocarcinoma after subtotal gastrectomy

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CASE REPORT

The authors present the case of a 71-year-old man with a history of a Billroth-II subtotal gastrectomy due to a mixed adenocarcinoma, stage pT4aN3aM0 (TNM classification), with adjuvant chemotherapy. Subsequent endoscopic and imaging evaluations revealed no signs of recurrence. Five years later, the patient was admitted with obstructive jaundice. Abdominal CT scan showed a diffuse mass close to the left hepatic lobe involving the common hepatic duct (Fig. 1), so a percutaneous biliary drainage was performed with symptomatic relief and analytical improvement. Consequent endoscopic evaluation integrity of the gastro-jejunostomy (Fig. 2) and permeable efferent loop. In the duodenal stump, an obstructive mass distal to the papilla major was seen (Fig. 3). Biopsies confirmed it was a relapse of mixed gastric adenocarcinoma.

DISCUSSION

Mixed type gastric cancers are highly metastatic and characterized by a more rapid disease progression, infiltrating both lymph nodes and the gastric wall, with a poorer prognosis than intestinal cancers (1). Locoregional recurrences after surgery seem to be more frequent in patients who have a fewer number of negative resected...
lymph nodes in the operative specimen (2). Duodenal stump late recurrences after curative surgery are rare, with less than six cases described in the literature, and usually present either as upper gastrointestinal bleeding or as an acute or chronic afferent loop syndrome with or without obstructive jaundice (3,4). One possible explanation results from invasion of the lymph nodes around the duodenal stump, which had been incompletely removed previously (5). Moreover, all previous cases involved the second, third or fourth portion of the duodenum, but none occurred in the first portion, making a metachronous cancer less probable. This case reinforces the need for a regular endoscopic follow-up of these patients, with careful exploration of the intestinal loops, particularly for more aggressive histological types.

REFERENCES